

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

FOR Item 19b film 587 1- STATE 1-30-84 cn REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Benjamin Frank Gable					2a. DATE OF DEATH MONTH DAY YEAR December 5, 1983					2b. HOUR 2:10 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-7-1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS - -		IF UNDER 24 HRS HOURS MIN. - -				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland, U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Steel						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7914 Allard Ct. Apt 202						
14. FATHER'S NAME FIRST MIDDLE LAST Frank Gable					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Austin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-7830		17. INFORMANT ADDRESS Chart.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4415 IMMEDIATE CAUSE (a) Cardio Respiratory arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Generalised Sepsis														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): 5/p Aortic aneurysm resection														
19a. DATE OF OPERATION 9/20/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Impending rupture of Aortic aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from November 19, 83 , to December 5, 1983 , that (I) (we) last saw the deceased alive on December 4, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Ronald H. Gonzalez M.D.								DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald H. Gonzalez M.D.					22e. ADDRESS 3001 South Hanover Street, Baltimore MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD								
24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md.														
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 5 - 1983 John J. Smith														

BP 396



100% COTTON
MADE IN U.S.A.

MADE IN U.S.A. 100% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
HAROLD David Gallery, Sr.			D	GALLERY	December 29, 1983					10:58 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White		March 20, 1911		72 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
New York	U.S.A.				Baltimore City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	St. Agnes Hospital				CWO - Ret		U.S. Coast Guard				
13a. STATE			13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE						
Maryland			Glen Burnie		3 - Thomas Road (21061)						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
David			Martha								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT (son)		ADDRESS				
Yes			1935-1967		Daniel F. Gallery		921 Roseanne Rd. Glen Burnie, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC STIMUS STILL</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>① SLE ② H10 GCCF ③ St. P. Thyroidectomy for Ca thyroid</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M. Elmour</u>				DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOHAMED F. ELNOUR				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				12/29/83			
22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE			
Burial		Jan. 4, 84		Arlington National		Ft. Myer		Virginia			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home				JAN 3 1984		John J. Carver					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Landrum Gallman					2a. DATE OF DEATH MONTH DAY YEAR 12 1 83		2b. HOUR 1:48 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 21 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21217 1516 Traction Street			
14. FATHER'S NAME FIRST MIDDLE LAST Smith Gallman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Hopkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 248-14-8653		17. INFORMANT ADDRESS Azalee Bass 6615 Springmill Circle					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V. DUE TO, OR AS A CONSEQUENCE OF (c) Suicidal ca of stomach PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 9/26/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED stomach ca				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 80 to Nov 21 19 83 , that (I) (we) last saw the deceased alive on Nov 21 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Myung H. Chung, M.D.				DEGREE MD				22c. DATE SIGNED Dec 2 '83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Myung H. Chung, M.D.				5670 The Alameda Baltimore, Md 21239					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Casper			

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DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR 1. STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) REBECCA GAMES					2a. DATE OF DEATH MONTH DAY YEAR DEC 30 1983			2b. HOUR 1237 AM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR DEC 09 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY SOM		13c. CITY OR TOWN CRISFIELD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Torney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Sterling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 213-10-8002		17. INFORMANT ADDRESS Edwin V. GAMES Crisfield, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 8903 IMMEDIATE CAUSE (a) CARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) BURNS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 60 HRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION DIABETES											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 PM 12 27 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) FIRE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/28/83 , 19 83 , to 12/30 , 19 83 , that (I) (we) lost saw the deceased alive on 12/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. Madden M.D.					DEGREE			22c. DATE SIGNED 12/30/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGH. MADDEN					22e. ADDRESS 4940 EASTERN AVE. BALT. MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/1/84		23c. NAME OF CEMETERY OR CREMATORY Asbury			23d. LOCATION CITY OR TOWN COUNTY STATE CRISFIELD Som MD			
24. FUNERAL DIRECTOR NAME Anthony E. Lane Crisfield MD. ADDRESS					25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE JAN 5 1984 John J. Lane						

MEDICAL CERTIFICATION

RECEIVED
JAN 10 1964
U.S. AIR FORCE

100

TO :

DA

FROM :
SUBJECT :

1. The purpose of this report is to provide a summary of the results of the investigation conducted during the period from 1 January 1963 to 31 December 1963. The investigation was conducted in accordance with the instructions of the Department of the Air Force, Office of the Inspector General, and the Air Force Office of Special Investigations.

2. The investigation was conducted in accordance with the instructions of the Department of the Air Force, Office of the Inspector General, and the Air Force Office of Special Investigations. The results of the investigation are summarized in the following paragraphs.

3. The investigation was conducted in accordance with the instructions of the Department of the Air Force, Office of the Inspector General, and the Air Force Office of Special Investigations. The results of the investigation are summarized in the following paragraphs.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 4 1 8

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William</i> <i>GANDEL</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12/5/83</i>		2b. HOUR <i>4:47A.M.</i>	
3. SEX <i>MALE</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>05 24 14</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69.</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City of Baltimore</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PROF. OFFICE MGR.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>BUSINESS</i>
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>RANDALLSTOWN</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>9008 SAMOSET RD. #21133</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>SIMON</i> <i>GANDEL</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH</i> <i>CHIDECKEL</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-05-1291</i>		17. INFORMANT <i>MRS. GERTRUDE GANDEL</i> <i>9008 SAMOSET RD. RANDALLSTOWN, MD 21133</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4148

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*4148*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> 19 <i>83</i> to <i>12/5</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/5</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. Edwards Franco</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/5/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Edwards Franco</i>				22e. ADDRESS <i>Sinai Hosp of Balto.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>DEC. 7, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>TIFERETH ISRAEL</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROSEDALE BALTO. MD</i>
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24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO. MD 21215</i>	25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Carried</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD GARDNER				2b. HOUR A 4:00M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 14 18		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS 16 S. Broadway		21231	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. 221108117		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer DUE TO, OR AS A CONSEQUENCE OF Cancer (c) Cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins 2-5 days Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 83 , to 12/27 , 19 83 , that (I) (we) last saw the deceased alive on 12/27/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (they/we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Katzenstein DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/27/83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR JAN 5 1984 REGISTRAR'S SIGNATURE John S. Conish			

100-2-1141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY B GARRETT			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1983			2b. HOUR 1:03P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10/10/17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home & Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook		12b. KIND OF BUSINESS OR INDUSTRY research cent.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Harmons		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7199 Ohio Avenue 21076	
14. FATHER'S NAME FIRST MIDDLE LAST Christopher C. Campbell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Yingling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-4627		17. INFORMANT ADDRESS Mr. Walter Wieland 7199 Ohio Ave 21076					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). RESPIRATORY FAILURE 4860 DUE TO, OR AS A CONSEQUENCE OF (b). CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c). PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from DECEMBER 26, 19 83, to DECEMBER 26, 19 83, that (b) (we) lost above (c) (we did) (did not) view the body after death.									
22b. SIGNATURE R. KANSARA				DEGREE R. KANSARA, MD.				22c. DATE SIGNED 12-26-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. KANSARA M.D.				22e. ADDRESS Church Hosp. Balto. MD. MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland			
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home				ADDRESS 1328 Sulphur Spring Rd.		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Lauer	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
SIDNEY					GARVINS JR	12				17	1983	1:00 P.M.	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male	Black		MONTH DAY YEAR 2 2 23		60 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				BALTIMORE CITY, MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE			PROVIDENT HOSP										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2014 Rayner Ave. 21217				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST Sidney Garvins					FIRST MIDDLE LAST Ethel Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS								
NO			218-18-1544		Vonita Booker 2014 Rayner Avenue								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIVER FAILURE</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC LIVER CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 11</u> , 19 <u>83</u> , to <u>DEC. 17</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>DEC 12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE					DEGREE					22c. DATE SIGNED			
<u>Donald J. Boatright</u>					<u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					12/17/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
DONALD J. BOATRIGHT					PROVIDENT HOSP.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL			12/22/83		Arbutus Memorial Pk			Arbutus, Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						DEC 19 1983			<u>John J. Connel</u>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (TYPE OR PRINT)		FIRST J.		MIDDLE Herbert		LAST Gaston		2a. DATE OF DEATH		MONTH 12	YEAR 12 83	2b. HOUR 305 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Oct. DAY 11, YEAR 1885		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		7. # UNDER 1 YEAR MONTHS 12 DAYS 12		7. # UNDER 24 HRS HOURS 305 MIN. A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD							
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b. KIND OF BUSINESS OR INDUSTRY Balt. City					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 East 25th St. 21218					
14. FATHER'S NAME FIRST Horace MIDDLE M. LAST Gaston		15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE H. LAST Vacher											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-9673		17. INFORMANT ADDRESS Ruth L. Noel 108 East 25th St. 21218									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE IMI 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 24 HRS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: @H.P. Fx, JUNCTIONAL RHYTHM													
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ~6 (P.M.) 12 12 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) FALL - Fx @ H.P.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET 108 E. 25th ST		CITY OR TOWN BALTO.		COUNTY MD		STATE MD			
22a. I certify that (I) (this hospital) attended the deceased from 12/11 , 19 83 , to 12/12 , 19 83 , that (we) (we) last saw the deceased alive on 12/12 , 19 83 , and that in (my) (our) opinion (we) (we) caused the death (we) (we) did not view the body after death.													
22b. SIGNATURE Vincent A. DiPietro				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/12/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT A. DIPIETRO				22e. ADDRESS 201 EAST UNIVERSITY PARKWAY									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 15 1983		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE [Signature]							

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) GOLDIE R. GEBELEIN					2a. DATE OF DEATH MONTH DAY YEAR Dec. 13 '83			2b. HOUR 3¹⁰ PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 9 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EDGEWOOD Nurs. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 3811 Canterbury Rd. 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Sherrer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-32-3007		17. INFORMANT ADDRESS Conrad G. Gebelein 6906 Lachlan Circle 21239					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4370 IMMEDIATE CAUSE (a) Cerebral Vascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis - DUE TO, OR AS A CONSEQUENCE OF (c) H.A.S.C.V.D.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peripheral Vascular Disease - lower Extremities -									
19a. DATE OF OPERATION 2-2-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Below Knee Amputation Rt. Leg				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/29/80 to 12/13 83 , that (I) (we) last saw the deceased alive on 12-13 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 83									
22b. SIGNATURE Anthony F. Carozza MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony F. Carozza				22e. ADDRESS 6000 Bellona Rd Baltimore 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 17 1983		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Maryland		25. DATE REC'D BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELLA MAE GENT			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1983		2b. HOUR 1:15 a.m.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 25 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Charleston, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae			17. STREET ADDRESS 501 Dolphin St.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219-03-7732 A		17. INFORMANT ADDRESS Wm.C. Brown Funeral Home 1206 W. North Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF (b) (MASSIVE STROKE) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE HYPERTENSION CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: with incarcerated greater omentum						
19a. DATE OF OPERATION December 2, 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated umbilical hernia		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 2, 1983 , to December 19, 1983 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 19, 1983 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.						
22b. SIGNATURE Michael W. Brown		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL W. BROWN MD		22e. ADDRESS c/o MARYLAND GENERAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. Brown Community F.H. 1206 W. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 20 1983		
				25b. REGISTRAR'S SIGNATURE John J. Smith		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

1-15

DECEMBER 19, 1983

DEPT

NAME

AREA

BALTIMORE CITY

MARYLAND GENERAL HOSPITAL

BALTIMORE

CARDIAC ARREST

(MASSIVE STROKE) Cerebrovascular accident

SEVERE HYPERTENSION

December 2, 1983 incarcerated medical inmate
with incarcerated inmate charges
x

December 19, 83
December 2, 1983
x
xxx
x

c/o MARYLAND GENERAL HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked unclear as to any injury, or other traumatic event, the medical examiner must be contacted at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST HARRY J. GEORGIUS		MONTH DAY YEAR 12 26 '83	
3 SEX MALE		2b. HOUR 6 ^{AM}	
4. RACE WHITE		5. DATE OF BIRTH	
		MONTH DAY YEAR 2 5 08	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter	
12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad			
13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Flora		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Grunder	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-05-4381	
17. INFORMANT Virginia L. East		ADDRESS 429 S. Gilmore St. 21223	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>4149</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>—</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>83</u> , to <u>12/26</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Bruce A. Bluff</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <u>12/26/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. Blumenthal</u>		22e. ADDRESS <u>700 WASHINGTON Blvd Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/83	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	
25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Eleanor, W. Gildea					2a. DATE OF DEATH MONTH 12 DAY 5 YEAR 83			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 30 YEAR 85		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		7b. HOUR 2345p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales		12b. KIND OF BUSINESS OR INDUSTRY retail	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST William MIDDLE Wickham LAST				15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-22-6560		17 INFORMANT ADDRESS Mr. Frank A. Purcell 6212 Hanover Rd. 21076				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan. 6, 1983 to Dec 5, 1983 , that (I) (we) last saw the deceased alive on 12/4/83 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John G. Healey MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Healey, MD				22e. ADDRESS St. Agnes Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 12/06/83		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Md.		
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home				ADDRESS 1328 Sulphur Spring Rd.		25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John G. Healey

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: SAC, [illegible]
SUBJECT: [illegible]
DATE: [illegible]
RE: [illegible]
[illegible text follows]

[illegible text follows]

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the space for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sophia SOPHIE T. GILLEASE		2a. DATE OF DEATH MONTH DAY YEAR 12/9/83		2b. HOUR 4:15 P ^M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Adam Andrejczuk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Dzieciatko		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-03-4024		17. INFORMANT ADDRESS Michael B. Gillease, Jr. Same as 13e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 METASTATIC ADVANCED COLON DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 12/9/83 to 12/9/83, that (I) (we) lost saw the deceased alive on 12/9/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE L. Ceballos MD		DEGREE MD		22c. DATE SIGNED 12/9/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LILIA CEBALLOS		22e. ADDRESS GOOD SAMARITAN HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-83	23c. NAME OF CEMETERY OR CREMATORY St. Francis	
23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon, Md.		23e. DATE REC'D. BY REGISTRAR DEC 12 1983		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.		25b. REGISTRAR'S SIGNATURE John J. Conner		

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) T Thomas LYLE GILLECE			2a. DATE OF DEATH MONTH DAY YEAR 12-3-83			2b. HOUR 9:10 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 21 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp. 3001 S. Hanover St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Balto.		12b. KIND OF BUSINESS OR INDUSTRY (City)		
13a. STATE Md			13b. COUNTY —		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 31 E. Heath Street Balto, Md. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS L GILLECE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE WELSH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown				16b. SOCIAL SECURITY NO. 215-074598		17. INFORMANT Mrs. Dorothy B. Gillece, Same as above				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) cardiac arrest 20 cardiac arrhythmia		4 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure 20 to acute tubular necrosis		2 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 11/2/83 + 11/4/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED peripheral vascular disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-19, 1983, to 12-3, 1983, that (I) (we) last saw the deceased alive on 12-3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorothy Stern ms				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOROTHEA STERN				22e. ADDRESS 3001 S. Hanover St. Balto, Md 21230			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 7, 1983		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COLON L18

CHIEFMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY M GILLIN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1983		2b. HOUR A 3:24 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 4, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1624 Chilton St 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Scardina		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-9375	17. INFORMANT ADDRESS Mr JOseph W Gillin 389 Spring Cove Rd Riva, Md 21140			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4149

IMMEDIATE CAUSE (a) **Cardiac arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Status post coronary artery bypass**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1983 , to Dec 26, 1983 , that (I) (we) last saw the deceased alive on 12-26-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Jeffrey R. Kursch	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-26-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey R. Kursch MD		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 N. Wolfe St Baltimore, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/29/83	23c. NAME OF CEMETERY OR CREMATORY Lake View	23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 27 1983	

20% COTTON FIB
CHILEAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Henry N. Gilmore				2a. DATE OF DEATH MONTH DAY YEAR December 18, 1983		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Caretaker	
12b. KIND OF BUSINESS OR INDUSTRY Cemetery							
13a. STATE Md		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 112 W. 27th Street		21211					
14. FATHER'S NAME FIRST MIDDLE LAST James Gilmore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Gallagher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 03 8661		17. INFORMANT ADDRESS Leona J. Gilmore same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4029 H. Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Arterio Sclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11</u> , 19 <u>81</u> , to <u>Dec 18</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) view the body after death.							
22b. SIGNATURE <u>Sheldon Goedgerer</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home				ADDRESS 3631 Falls Road 21211		25a. DATE REC'D. BY REGISTRAR DEC 20 1983	
				25b. REGISTRAR'S SIGNATURE <u>Joan J. Connel</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 28, report any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna m Glass					2a. DATE OF DEATH MONTH DAY YEAR Dec 24 '83				2b. HOUR 3:10 P.M.				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 26 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 134 N. PORT ST.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH Zomkowski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST APOLONIA Wysocka								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DOROTHY MARTIN 4503 WILKS HIRE AVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4151 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>immediate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>83</u> , to <u>12-24</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE George M Boyer MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/24/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George M Boyer MD						22e. ADDRESS 301 St Paul Place Baltimore MD 21202							
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL				23b. DATE 12-29-1983		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD					
24. FUNERAL DIRECTOR NAME R.L. KACZOROWSKI						ADDRESS 2525 FLEET ST		25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]			

MEDICAL CERTIFICATION

100

CHIEF



50% COOL FIB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) H. GABRIEL GLICK		2a. DATE OF DEATH MONTH DAY YEAR DEC. 4 1983		2b. HOUR 8:30 A.M.	
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug. 11 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GERIATRIC CENTER - HOSPITAL		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) MANUFACTURER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 SLADE AVE. APT. 608 21208
14. FATHER'S NAME MIDDLE LAST MYER GLICK		15. MOTHER'S MAIDEN NAME MIDDLE LAST RACHEL WEINBERG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-07-4849		17. INFORMANT ADDRESS MRS. GERTRUDE GLICK 7 SLADE AVE., APT. 608 #21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CONV. ASCUT W/ CHF					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 9/22 , 19 83 , to 12/4 , 19 83 , that (we) lost saw the deceased alive on 12/4 , 19 83 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.					
22b. SIGNATURE Estrelita O. Kn		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KN		22e. ADDRESS LOVINATHE HEBREW GERIATRIC CENTER - HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 5, 1983		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25. DATE REC'D. BY REGISTRAR DEC 6 1983	
				25b. REGISTRAR'S SIGNATURE John J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHILD-MAIN

20% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JACOB RAYMOND GNAGEY, SR		2a. DATE OF DEATH		MONTH DAY YEAR 12 18 83		2b. HOUR 5:30 A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 15 95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good SAMARITAN HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY		12b. KIND OF BUSINESS OR INDUSTRY HOTEL	
13a. STATE MARYLAND		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1704 West Lombard St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Gideon J. GNAGEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WARNICK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -		16b. SOCIAL SECURITY NO. 216-18-1592		17. INFORMANT 12911 Kanes Rd. SALLY BRUND, Glen Arm, MD. 21057	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 CEREbroVASCULAR ACCIDENT, RECURRENT. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/18/83 to 12/18/83, that (I) (we) last saw the deceased alive on 12/18/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE L. Ceballos, MD				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LILIA CEBALLOS				22e. ADDRESS GOOD SAMARITAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/21/83		23c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE GRANTSVILLE GARRETT, MD.			
24. FUNERAL DIRECTOR NAME A. Lynn Newman				ADDRESS GRANTSVILLE, MD.		25. DATE REC'D. BY REGISTRAR DEC 27 1983			
						REGISTRAR'S SIGNATURE John J. Garret			

MEDICAL CERTIFICATION



TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text block containing several lines of typed information, including dates and names.]

COPIES TO:
FBI
[Illegible]



ADMINISTRATIVE: [Illegible]
[Illegible text block at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must see notified and advise.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 32434			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST HARRY Goldie				20. 12 20 83 5:12AM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 3 27		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 56 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. SUPERVISOR (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	
13a. STATE MARYLAND		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TIBIE unknown		16. SOCIAL SECURITY NO. 081-20-5813		17. INFORMANT MRS. FRITZI GOLDIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN WWII-NAVY		16b. SOCIAL SECURITY NO. 081-20-5813		17. INFORMANT MRS. FRITZI GOLDIE		17. ADDRESS 3706 ALLENSWOOD CT, RANDALLSTOWN, MD 21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1540 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic colorectal Ca & hepatic metastasis DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)		21h. PHYSICIAN'S NAME (TYPE OR PRINT) BRIANT ROEDER	
21i. DATE OF SIGNATURE 12/20/83		21j. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		21k. ADDRESS SINAI HOSPITAL = BALTO., MD		21l. DATE SIGNED 12/20/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK		23d. LOCATION CITY OR TOWN BALTO. MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Casper	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		12		21 83	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		01 16 35		48		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.		HOURS	
MARYLAND		USA				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Univ. of Maryland Hosp		SECRETARY		UNIV. OF BALTO.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS							
13a. STATE		13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8816 Sigurd Rd		#21133					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Simon		Amelia									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		215-32-6001		David Goldman		8816 Sigurd Rd, Randallstown					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
0389		Sepsis				3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		Renal Cell Cancer									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (he) (this hospital) attended the deceased from		Dec 21 19 83		to Dec 21 19 83		that (we) lost					
saw the deceased alive on		above (he) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Dennis J. Grangulis MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/21/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dennis J. Grangulis MD		Univ. Maryland Hosp. Balt, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY	
BURIAL		DEC. 22, 1983		OHEB SHALOM MEM. PARK		REISTERSTOWN		BALTO.		MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SOL LEVINSON & BROS., INC.		DEC 20 1983		Sam J. Connel							
6010 REISTERSTOWN RD. BALTO., MD		21215									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-3333.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nathaniel Goldsmith				2a. DATE OF DEATH MONTH DAY YEAR December 15, 1983			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 27 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1211 N. Eden St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Goldsmith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Kizzie Goldsmith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16a. SOCIAL SECURITY NO. 218-05-1077		17. INFORMANT ADDRESS Myrtle Lewis 1211 N. Eden Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Plasma Cell Leukemia 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myeloma 1980 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 6 , 19 83 , to Dec 15 , 19 83 , that (I) (we) last saw the deceased alive on Dec 15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George Taler, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 16, 83	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) George Taler, M.D.				23b. ADDRESS 600 Light St. Balt. Md. 21230			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 12/19/83		23e. NAME OF CEMETERY OR CREMATORY Holly Hill Cem		23f. LOCATION CITY OR TOWN COUNTY STATE White Marsh Md	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 19 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conish			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANN SYLVIA GOLDSTICK				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16 1983				2b. HOUR 5 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 23, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONIC CO.			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6012 WOODCREST AVE. 21209			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL TEWLOW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-5584		17. INFORMANT MR. ISADORE GOLDSTICK				6012 WOODCREST AVE. BALTO., MD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Interstitial lung metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary adenocarcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Basal ganglia (R) ppt. temp. brain region lesion</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 05, 1983</u> to <u>DEC 16, 1983</u> , that (I) (we) lost saw the deceased alive on <u>DEC 15, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Elena Barraquer</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 12/16/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELENA BARRAQUER		22e. ADDRESS SINAI HOSPITAL OF BALTO.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 18, 1983		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT GOODEN			2a. DATE OF DEATH MONTH DAY YEAR December 30, 1983		2b. HOUR 7:35a M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 17 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1300 E. Lanvale St. 21213
14. FATHER'S NAME FIRST MIDDLE LAST James Gooden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Starks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 251 18 5998		17. INFORMANT ADDRESS Mary Gooden 1300 E. Lanvale St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulm Arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic Cancer and Hypertension DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 18 , 19 83 , to Dec. 30 , 19 83 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 30 , 19 83 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE A. Kazakis M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. KAZAKIS MD.				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/5/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 3 1984	
				25b. REGISTRAR'S SIGNATURE John E. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.



UNITED STATES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM OWEN GOODRICH			2a. DATE OF DEATH MONTH DAY YEAR 12/ 17/ 83		2b. HOUR 156 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 17 1899		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN		
12b. KIND OF BUSINESS OR INDUSTRY CITY OF		13a. STREET ADDRESS 1820 SPENCE STREET, 21230		13b. BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES GOODRICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE DOUD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW I		
16b. SOCIAL SECURITY NO. 215-46-6504		17. INFORMANT ADDRESS CHARLES GOODRICH 1231 NEWFIELD ROAD, 21207				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 ASCVD with Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac face major infarction DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatoid Arthritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks 3405	
--	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 16 MAR 1983 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE KESWICK, 700 W. 40TH STREET			
22a. I certify that (I) (this hospital) attended the deceased from 16 MAR 1983 to 17 Dec 1983 , that (I) (we) lost saw the deceased alive on 17 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Aubrey B. Richardson M.D.				DEGREE M.D.		22c. DATE SIGNED 17 Dec 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AUBREY B. RICHARDSON, M.D.				22e. ADDRESS KESWICK, 700 W. 40TH STREET			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 19 1983	
				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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JAN 10 1910



TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES

OF THE
STATE OF NEW YORK

IN SENATE

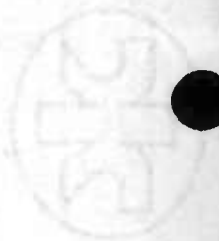
REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 10 1910



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
ROY		LEE		GOODWIN				12		7		19		83				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	Black	10 31 31		52 YRS.						12		7		19		83		5:12 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Virginia		U.S.A.										Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		219 N. Duncan St.																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		219 Duncan Street 21231											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
Giford				Goodwin		Margaret				Goodwin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		225-36-1848		Eleanor Goodwin		1733 Orleans St.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		12-8-83													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201															
Ann M. Dixon, M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		12/12/83		Eastview Mem. Pk.		Baltimore, Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wm C March F/H Inc.		1101 E North Ave.		DEC - 9 1983		John J. Carver													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1. ATTACH PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

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OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
JAN 10 1900

COPIES

NOV 10 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUE ANNA GORDON				12 4 83			
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 05 24 1883		6. AGE (IN YEARS LAST BIRTHDAY) 100	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2407 Talbot Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Perfy Grodon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Glenva Coleman 2407 Talbot Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>83</u> , to <u>Dec 4</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Nov</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. E. E. E. E.				DEGREE MD 22e. ADDRESS 2717-HAMMOND FERRY RD BALDWIN MD 21227		22c. DATE SIGNED 12/5/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Gordon Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Kimbridge Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Bell Funeral Home Alexandria Va.				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

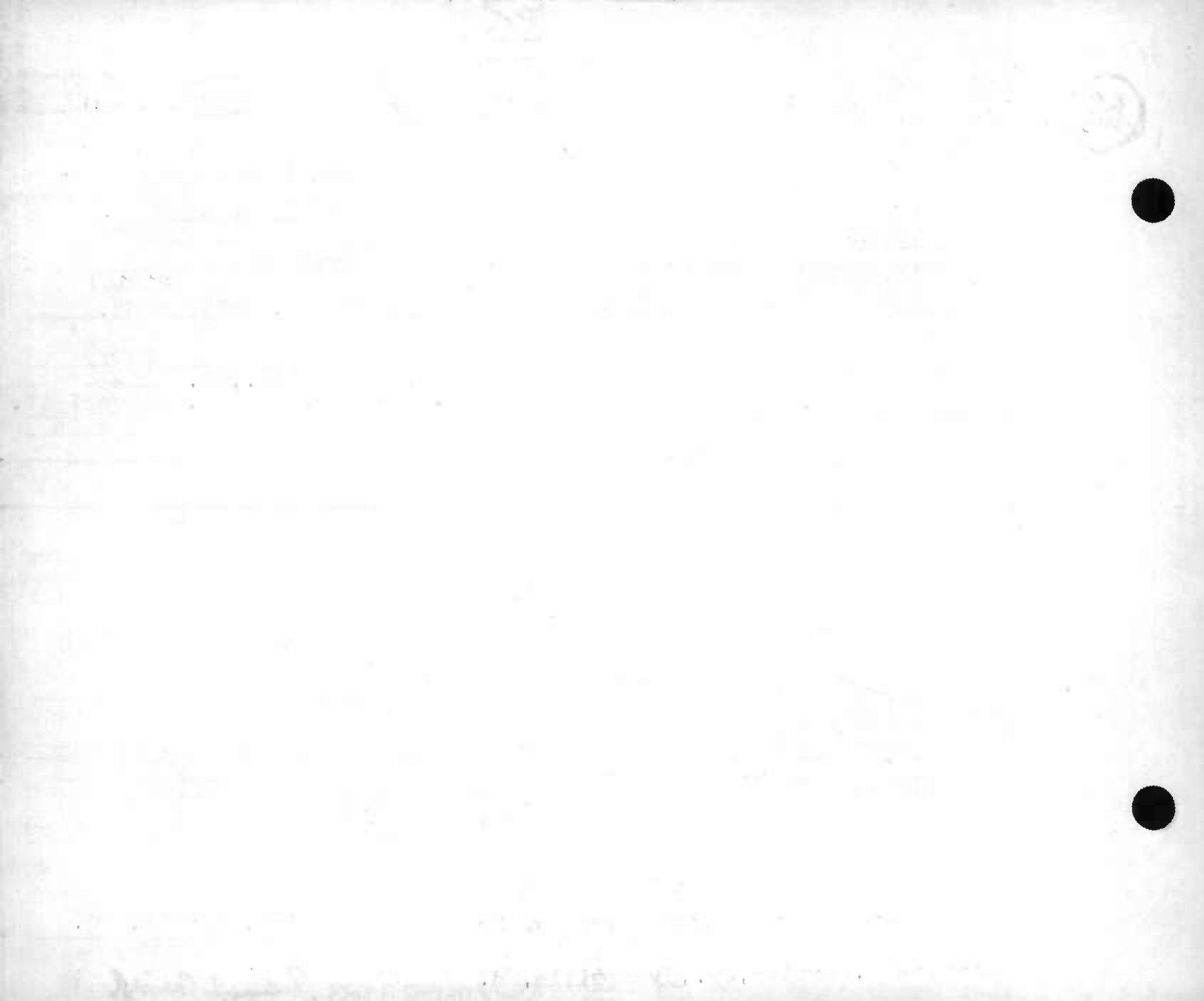
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jane (NMN) Gosnell				12-21-83			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7-14-96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Long Green		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John McWilliams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Jane Perry		16. STREET ADDRESS (21218) 2730 N. Calvert St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-0340		17. INFORMANT ADDRESS Mary L. Shelley, 2730 N. Calvert St. Balt8., Md. 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Basaloid Xeroderma</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 2000
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Alzheimer's Disease</u>							
19a. DATE OF OPERATION ✓		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> 19 <u>76</u> to <u>Dec 7</u> 19 <u>83</u> , that (I) (we) saw the deceased alive on <u>Dec 7</u> 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death.							
22b. SIGNATURE <u>DRE BERTSON</u>				DEGREE 1720 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DRE BERTSON				22e. ADDRESS 302 E 33RD St BALTO 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-1983		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Woodbine, Carroll, Md.	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Carls	

BP

DHMH-16 20M
(VRA 15, 4) 7/78

DEC 29 1983



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
PHOEBE GRADY

2a. DATE OF DEATH MONTH DAY YEAR
12/6/83

2b. HOUR
2204 M

3. SEX
FEMALE

4. RACE
BLACK

5. DATE OF BIRTH MONTH DAY YR
9 5 05

6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA

7b. CITIZEN OF WHAT COUNTRY?
U.S.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.

10. CITY OR TOWN OF DEATH
Balto

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MD

13b. COUNTY

13c. CITY OR TOWN
BALTO

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS
3613 Lockwood Rd 21207

14. FATHER'S NAME FIRST MIDDLE LAST
JOHN WHITFIELD

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE CUNNINGHAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO

16b. SOCIAL SECURITY NO.
243050579

17. INFORMANT ADDRESS
JAMES O.W. GRADY 3613 Lockwood Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4100

IMMEDIATE CAUSE (a) **CARDIAC RESP ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **acute MI, pulmonary edema**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Dehydration, Acidosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **12/5**, 19 **83**, to **12/6**, 19 **83**, that (I) (we) last saw the deceased alive on **12/6**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Kang Sun Lee MD

22c. DATE SIGNED
12/6/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KANG SUN LEE

22e. ADDRESS
SINAI HOSPITAL

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
12/10/83

23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE CEM.

23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO MD

24. FUNERAL DIRECTOR
LEROY O. DYETT & SON F.H., Inc.

25a. DATE REGD. BY REGISTRAR
DEC 08 1983

25b. REGISTRAR'S SIGNATURE
John J. Connelley

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified at once.

107

CHIEF CLERK

SECTION 10

107

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 4 4 4 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) John Joseph Graff						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12 4 1983		7b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 5, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 4 1983		2d. HOUR 4:36A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sergeant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2309 McElderry St. 21205			
14. FATHER'S NAME Jacob F. Graff				15. MOTHER'S MAIDEN NAME Anna Shaw							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) W.W. II		16b. SOCIAL SECURITY NO. 215-14-9747		17. INFORMANT ADDRESS Mrs. Edna Ziarnowski 1005 W. Baltimore St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith, M.D.		TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12/4/83					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, - Maryland					
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. ADDRESS 1901 Eastern Ave./21231				25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE Joan J. Connel					

U.S. Army

Department

X

United States

Marion

Marion, Miss. Aug. 2, 1913

Post No.

Post No. 1015-1

X

Bellevue

Bellevue

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Post No. 1015-1

Post No. 1015-1

Post No. 1015-1

Post No. 1015-1

Marion

Marion

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Marion

Marion, Miss. Aug. 2, 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MAMIE MIDDLE THERESA LAST GRAHAM					2a. DATE OF DEATH MONTH 12 DAY 19 YEAR 83		2b. HOUR 4:15 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 09 DAY 11 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE MARYLAND		13b. CITY OR TOWN ---	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS: 2233 RAMSAY STREET, 21223			
14. FATHER'S NAME FIRST MIDDLE LAST GUSTOV PRITCHARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AUGUSTA UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-16-5356		17. INFORMANT ADDRESS JAMES W. MYER 210 S. SMALLWOOD STREET 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute pulmonary edema, renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Acute Anterolateral MI</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/83</u> 19 <u>83</u> to <u>12/19/83</u> 19 <u>83</u> that (I) (we) last saw the deceased alive on <u>12/19/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Uma Prasad</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/19/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>UMA PRASAD</u>				22e. ADDRESS <u>SINAI HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-22-83		23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE CARROLL MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR DEC 21 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

BP

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11/11/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Harvey GRANGER				2b. HOUR 9:50P M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1919		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 63	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City 21224 MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Bethel-Steel Co	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1713 Melvern St. Balto, Md 21224		14. FATHER'S NAME FIRST MIDDLE LAST Percy Granger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clemie Sinc			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 212 14 1051		17. INFORMANT ADDRESS Marleen Langston 7925 Trapp Rd Balto, Md 22			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Ruptured Aortic Aneurysm 4416 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Electrical Mechanical Dissociation							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that XX (this hospital) attended the deceased from December 2 , 19 83 , to December 3 , 19 83 , that (X) (we) last saw the deceased alive on December 3 , 19 83 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do) not view the body after death.							
22b. SIGNATURE Harry E. Nervino, M.D.				DEGREE M.D.		22c. DATE SIGNED 12-3-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry E. Nervino, M.D.				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/83		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Walter Dabrowski 1005 Dundalk Avenue 21224				25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Canine	

Walter Gaborowski 1005 Dupont Avenue 21214

DEC 8 1983

Baltimore, Maryland

Harry A. Kervino, M.D.

C/O Maryland General Hospital

12/7/83

Burial

December 3

December 3

12-3-83

Electrical Mechanical Division

Possible Reported Toxic Ammunition

Yes

11/14/1971

Marion L. Scott 2025 Trump Rd Baltimore, Md 21

Party

Assembly

City of

State

Maryland

Baltimore

X

1713 Belvoir St. Baltimore, Md 21218

Baltimore

Maryland General Hospital

Academic

Health-Staff Co

Maryland

USA

X

Baltimore City

21114

Male

White

11

18 1919

63

Marion

Private

CRAWFORD

December 3, 1983 9:50P

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>JERRY L. GRAVES</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 28 83</i>		2b. HOUR <i>4 P M</i>	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 27 10</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NO. CAROLINA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CITY</i> MD.		
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BON. SELOMONS</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>		13b. COUNTY	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1918 RUXTON AVE 21216</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>PETER GRAVES</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HARRIET WATKINS</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>23916358</i>		17. INFORMANT ADDRESS <i>WIFE BEATRICE GRAVES 1918 RUXTON AVE</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe cachexia and malnutrition</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Colon with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>Severe malnutrition of long standing duration</i>						
19a. DATE OF OPERATION <i>12/16/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Partial intestinal obstruction</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/16</i> , 19 <i>83</i> , to <i>12/28</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12/28</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>M. A. Sarshar, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/30/83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SARSHAR</i>		22e. ADDRESS <i>3455 Wilkens Ave 21229</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/3/1984</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>NUTTER & SONS 2501 Gwynns Falls</i> ADDRESS <i>Funeral Home Inc. Pkwy. Baltimore, Md. 21216</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 3 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

73

UNITED STATES DEPARTMENT OF AGRICULTURE

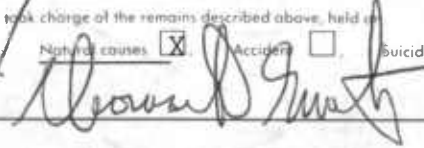

WASHINGTON, D. C. 20250

OFFICE OF THE ASSISTANT SECRETARY FOR RESEARCH AND STATISTICS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NOTICED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 4 4 3 REG. NO.	
1- STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William C. Graves										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/11/83	
2. SEX Male		4. RACE Black		5. DATE OF BIRTH (MONTH DAY YEAR) 5 23 21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4821 Reisterstown Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4821 Reisterstown Rd. 21215			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.				16b. SOCIAL SECURITY NO. 202-01-4160A		17. INFORMANT ADDRESS Mr. Larry Brown (Same as #13.)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Dep. Chief				MEDICAL EXAMINER		DATE SIGNED 12/12/83	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 12/20/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE 			



ONE

TOBACCO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

3

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine Gray			2a. DATE OF DEATH MONTH DAY YEAR 12 24 83		2b. HOUR 2:40 A.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 22 00		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	# UNDER 1 YEAR MONTHS DAYS - -
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH City MD.		
10. CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON Secours Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 7355 Furnace Branch Rd 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Promise			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 2121800617	17. INFORMANT JAMES H. JOHNSON, Sr. 46 Pleasant St. Annapolis, Md. 21401		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure - Cardio Pulm - any arrest DUE TO, OR AS A CONSEQUENCE OF (b) + CVA Atherosclerotic coron. vasc. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard N. Robinson, M.D.		DEGREE M.D.		22c. DATE SIGNED 12-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Robinson		22e. ADDRESS Bon Secours Hosp., Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-30-1983	23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. FARM		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland	
24. FUNERAL DIRECTOR Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR JAN 4 1984 REGISTRAR'S SIGNATURE John J. Lauer			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST LACEY (Lacie)	MIDDLE F.	LAST Gray	2a. DATE OF DEATH MONTH DAY YEAR 12/29/83		2b. HOUR 6:49P _M	
3 SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 1 35		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 709 N. Kenwood Ave. 21205
14. FATHER'S NAME FIRST MIDDLE LAST Moses Fitzgerald				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Purnell Vaughn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-30-0384		17. INFORMANT ADDRESS Rosa F. Harris 707 N. Curley Street				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 7100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>systemic Lupus Erythematosus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 days</u> <u>2 months</u>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Candida infection, Hepatic failure, Renal failure, sepsis

19a. DATE OF OPERATION 12/20/83	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal failure	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME-STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 9 19 83 to Dec 29 19 83, that (I) (we) last saw the deceased alive on Dec 29 19 83, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.

22b. SIGNATURE <u>GB Bolger MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Dec 29/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Graeme B Bolger MD		22e. ADDRESS 600 N Wolfe Street Baltimore MD 21205	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/4/84	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.
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24. FUNERAL DIRECTOR NAME ADDRESS Wm C MARCH F/H Inc, 1101 E North Avenue	25a. DATE REC'D. BY REGISTRAR JAN 3 1984	25b. REGISTRAR'S SIGNATURE <u>Re. J. C. C.</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



12/20/23 - From [illegible]
Consider [illegible] for [illegible]
system [illegible] [illegible]
Metabolic [illegible]
[illegible] [illegible]

23 Dec 23
[illegible]
[illegible]
[illegible]

FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Rose F. Graziano			12-23 1983			a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
FEMALE	WHITE	4/11/1907	76 YRS			12-23 1983	11:50 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
SICILY, ITALY		U.S.A.				Baltimore City, MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY
Baltimore		University Hospital - STU				HOMEMAKER		
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
VIRGINIA		FAIRFAX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7150 SONTAG WAY-22153-99999		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
GAETANO BONGIORNO			SARAH UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
NO		053.09.3282		JOHN A. GRAZIANO		SAME AS 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: Multiple Injuries								
8147 IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			10:59x 12-23 1983		pedestrian struck by auto			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			highway		I-95 south of White Marsh Blvd., Balto.Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Dennis F. Smyth, M.D.			Assistant			12-24-83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
CREMATION		12/26/1983		GREEN MOUNT CREMATORY		BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222				DEC 28 1983		John J. Conner		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Vincent Greco			2a. DATE OF DEATH MONTH DAY YEAR December 2, 83			2b. HOUR 3:48 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27 22		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bar. Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7853 Americana Cir #102			
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Greco				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salvadora Sears					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 184-18 4513		17. INFORMANT Wife		ADDRESS Same as 43			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 83 , to 12/2 , 19 83 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven G. Gevas						DEGREE MD		22c. DATE SIGNED 12/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN G. GEVAS M.D.						22e. ADDRESS 22. S. Greene Street. Balt. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE Dec. 6, 83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		
24. FUNERAL DIRECTOR NAME Singleton Funeral Home						ADDRESS Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR DEC 6 1983	
						25b. REGISTRAR'S SIGNATURE John J. ...			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Charles H. ...
1888

White ...
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAHLON P. GREEN		2a. DATE OF DEATH MONTH 12 DAY 7 YEAR 83		2b. HOUR 7:30 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 4 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John H. & Helen Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman,		12b. KIND OF BUSINESS OR INDUSTRY Box Factory		13a. STREET ADDRESS 23 E. Fort Ave. Balto. Md. 21230	
13b. STATE Maryland		13c. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Joshua MIDDLE ----- LAST Green		15. MOTHER'S MAIDEN NAME FIRST Willie MIDDLE T. LAST Hooftagle		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 212-07-3862A		17. INFORMANT Mrs. Nadine Crossney, 34 Broadship Rd. Balto. Md.		17. ADDRESS 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF

1629
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**8 mos.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12-2 , 19 83 , to 12-7 , 19 83 , that (1) (we) lost saw the deceased alive on 12-6 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE afred I. Daniel MD				DEGREE MD		22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Baltimore, COUNTY Maryland STATE	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230				25a. DATE REC'D. BY REGISTRAR DEC 9 1983			
				25b. REGISTRAR'S SIGNATURE John J. Lauer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

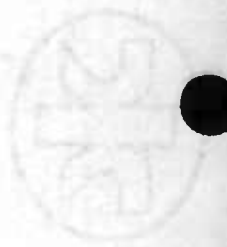
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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Alfred J. Davis Jr.
10/2/73



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

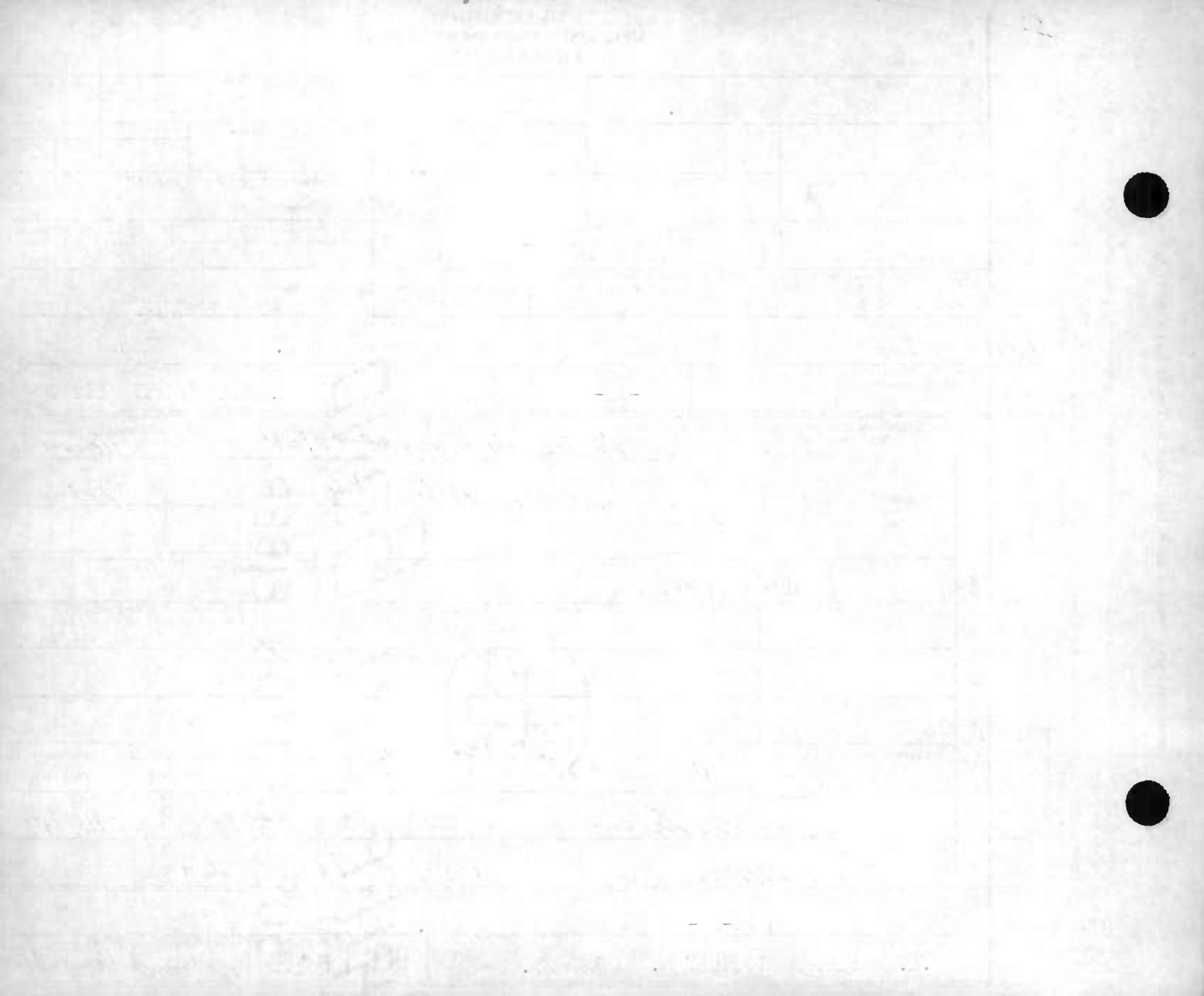
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALGIA K. GREEN			2a. DATE OF DEATH MONTH DAY YEAR 12 15 83			2b. HOUR M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 23 20		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 63	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6817 PARSONS STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST MASON GREEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE FLORA B. BARNES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215-12-9908		17. INFORMANT ADDRESS ELLEN GREEN 6817 PARSONS STREET 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes year
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/18/80 to 12/11 19 83 , that (I) (we) lost 11/14 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S.H. MALINOW DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.H. MALINOW				22e. ADDRESS 3635 Old Court Rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-19-83		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VET.		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE MARYLAND	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS				ADDRESS 1724 27 N. MINROE ST.		25a. DATE REC'D. BY REGISTRAR DEC 16 1983	
						25b. REGISTRAR'S SIGNATURE John J. Connel	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Hilda Greenfield</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 29 83</i>			2b. HOUR <i>3:00 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 28 1907</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>76</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6048 Cecil Ave. 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Morrissey</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Louise Palmer</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Unknown</i>		17. INFORMANT ADDRESS <i>Washington D.C. 20007</i> <i>Sister Louise Greenfield 3601 Reservoir Rd N.W.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100 Reentrant Ventricular tachycardia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic coronary vascular disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THEIR TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>4100</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>December 22, 1983</i> to <i>December 29, 1983</i> , that (I) (we) lost saw the deceased alive on <i>December 21, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Brenda M. Brandon MD</i>					DEGREE		22c. DATE SIGNED <i>12/29/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Brenda M. Brandon MD</i>					22e. ADDRESS <i>Mercy Hospital 1st Paul St Baltimore Md 21201</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 30, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>George J. Gonce 4001 Ritchie Hw. Balto. Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>JAN 4 1984</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICA GRENLEY				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1983		7b. HOUR P. 1:35 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAR. 5, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 W. COLDSPRING LA., APT. 509W			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST AARON COHEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNA HARTZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT AARON GRENLEY ADDRESS 1 DUNSCOMBE CT. PHOENIX, MD 21131		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> 10 years						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/47</u> 19 <u>47</u> , to <u>12/23/83</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/22/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>A. A. Silver</u>		DEGREE		22c. DATE SIGNED 12/24/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. A. SILVER		22e. ADDRESS 6210 Park Heights Ave		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE DEC. 26, 1983		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		23e. DATE REC'D. BY REGISTRAR DEC 30 1983				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		24b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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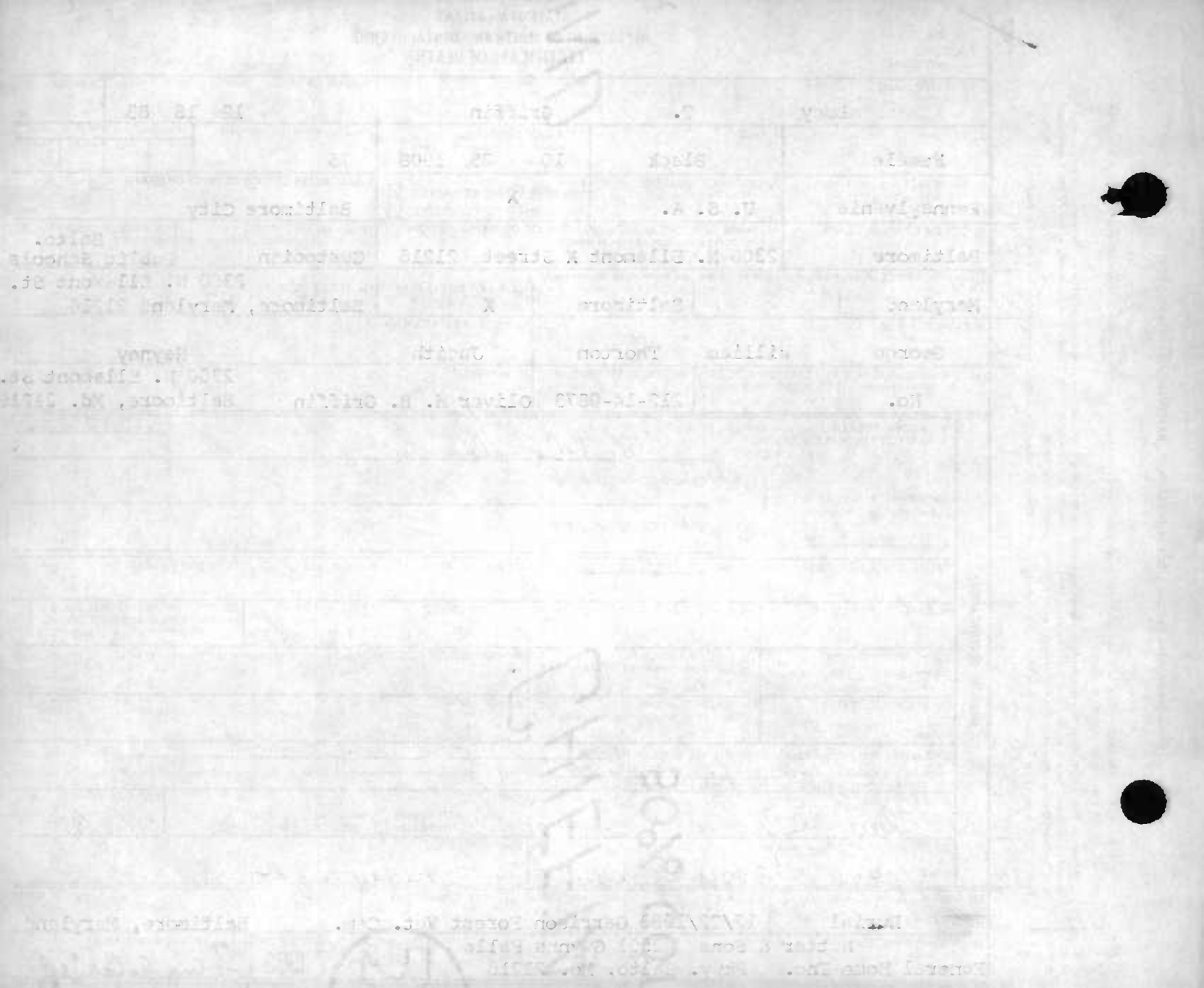
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucy T. Griffin			2a. DATE OF DEATH MONTH DAY YEAR 12 18 83			2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 25 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2300 N. Ellamont X Street 21216				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Balto. Public Schools	
13a. STATE Maryland			13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2300 N. Ellamont St. Baltimore, Maryland 21216		
14. FATHER'S NAME FIRST MIDDLE LAST George William Thorton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Judith Hayney			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.			
16b. SOCIAL SECURITY NO. 212-14-0873			17. INFORMANT Oliver H. B. Griffin			ADDRESS 2300 N. Ellamont St. Baltimore, Md. 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) <i>mitral valve disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.									
22b. SIGNATURE <i>Steve Klassen</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Klassen S. Klassen				22e. ADDRESS 600 Reservoir Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/1983		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Nutter & Sons Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

BP _____



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irwin M Grinsfelder			2a. DATE OF DEATH MONTH DAY YEAR 12-08-83			2b. HOUR 5:47 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 16, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESIDENT		12b. NAME OF BUSINESS OR INDUSTRY BALTO. TOWEL SUPPLY & LNDRY.		
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #21210 CO 116 W. UNIV. PKWY., APT. 333	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY GRINSFELDER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE HELDMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-10-6381		17. INFORMANT MRS. HELENE S. GRINSFELDER ADDRESS APT. 333 116 W. UNIVERSITY PKWY. #21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION 11-16-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pancreatic mass			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-13-83 , 19 83 , to 12-8 , 19 83 , that (I) (we) lost saw the deceased alive on 12-8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Howard Steiner MD			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-9-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HOWARD STEINER			22e. ADDRESS 600 N. WOLFE ST. BALTO., MD. 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE DEC. 12, 1983		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. But it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



WHITE

SEPT. 16, 1906
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77

USA

BALTIMORE

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116 W. UNIV. PKWY., APT. 333

GRINSFELDER

FLORENCE

HEIDMAN

MRS. HELENE G. GRINSFELDER

216-10-6381 APT. 333 116 W. UNIVERSITY PKWY. #21210

BALTO. TOWEL
SUPPLY & LNDRY.
CO #21210

PRESIDENT

3

16-22a 3/12/84 mtf 17-589

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST ANNIE

MIDDLE

LAST

(Anna)

B.

Grove

2a. DATE KNOWN
OF DEATHMONTH DAY YEAR
☒ 12-23 1983

2b. HOUR

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH
MONTH DAY YEAR
6 10 406. AGE (IN YEARS
LAST BIRTHDAY)
43 YRS.IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN.7c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
12-27 19832d. HOUR
4:45 p. M.7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

S. Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

836 Hillman Court

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland

13b. COUNTY

13c. CITY OR TOWN
Baltimore13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS
836 Hillman Court 21202

14. FATHER'S NAME

FIRST Hayward

MIDDLE

LAST Byrd, Sr.

15. MOTHER'S MAIDEN NAME

FIRST Annie

MIDDLE

LAST Mae

Hopkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
218-36-4018

17. INFORMANT

ADDRESS

Hayward Byrd, Jr. 1714 N. Milton St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Undetermined

7999

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE*Dennis F. Smyth*TITLE (SPECIFY)
Assistant

MEDICAL EXAMINER

DATE SIGNED 12-28-83

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

12/31/83

23c. NAME OF CEMETERY OR CREMATORY

Mount Auburn Cemetery

23d. LOCATION
CITY OR TOWN

Baltimore,

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Wm C March F/H Inc. 1101 E. North Avenue

25a. DATE REC'D. BY REGISTRAR

DEC 30 1983

25b. REGISTRAR'S SIGNATURE

John J. Connelley

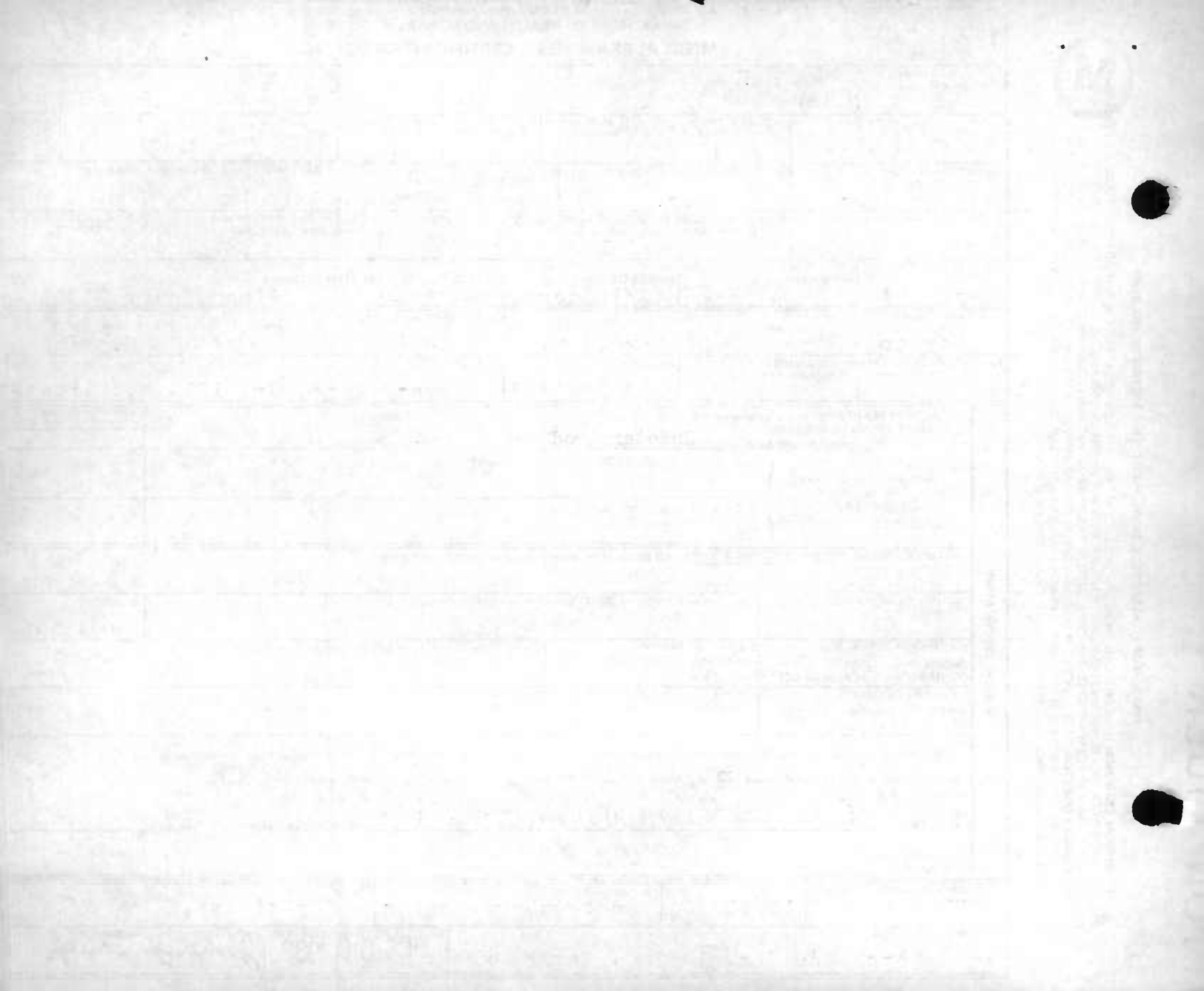
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

473

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASON FOR DELAY SHOULD BE STATED IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Wilhelm</u> MIDDLE <u>Carl</u> LAST <u>Grube, Jr.</u> <u>WILHELM CARL GRUBE.</u>		2a. DATE OF DEATH MONTH <u>December</u> DAY <u>24</u> YEAR <u>83</u>		2b. HOUR <u>11:15 PM</u>
1. SEX <u>Male</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH <u>Nov.</u> DAY <u>14</u> YEAR <u>32</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>51</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <u>Univ of Maryland</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Comp. Analyst</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Civil Serv.</u>
13a. STATE <u>MD</u>	13b. COUNTY <u>Anne Arundel</u>	13c. CITY OR TOWN <u>SEVERN</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>8123 New Ct Rd.</u> (21144)
14. FATHER'S NAME FIRST <u>WILHELM</u> MIDDLE <u>C.</u> LAST <u>GRUBE-SR</u>		15. MOTHER'S MAIDEN NAME FIRST <u>MARIE</u> MIDDLE <u>Wonne</u> LAST <u>Riemer</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. <u>213366363</u>		17. INFORMANT Wife Karen E. Grube ADDRESS Same as 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO Resp Arrest</u> <u>2396</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAN TUMOR</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>DAYS</u> <u>3 WKS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>				
19a. DATE OF OPERATION <u>12/5/83</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hydrocephalus</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> , 19 <u>83</u> , to <u>Dec 24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec 24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Daniel J. Wonn</u>			22c. DATE SIGNED <u>12/25/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANIEL J. Wonn MD</u>			22e. ADDRESS <u>22 S. Greene St.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Dec. 29, 83</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Mem Pk.</u>	23d. LOCATION CITY OR TOWN <u>Sykesville</u> COUNTY <u>Carroll</u> STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home, Glen Burnie, MD</u> ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>DEC 28 1983</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Linnick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Their license requires certain papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer C Gubernatis			2a. DATE OF DEATH MONTH DAY YEAR 12 18 83			2b. HOUR 4 AM	
3. SEX ♂ M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 30 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICE OFF.	
12b. KIND OF BUSINESS OR INDUSTRY BALTO CITY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. 13b. COUNTY Balt. 13c. CITY OR TOWN Balt.					
14. FATHER'S NAME FIRST MIDDLE LAST PETER F GUBERNATIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILIA VON MACH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-03-8695			
17. INFORMANT AGNES GUBERNATIS		18. ADDRESS 351 GREENLAW RD					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Right CVA**

4360

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 83 , to 12/18 , 19 83 , that (I) (we) last saw the deceased alive on 12/17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. Halluck M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. HALLUCK MD				22e. ADDRESS St. Agnes Hosp.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME		ADDRESS 5311 EDMON- DSOON AVE.		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed by a medical examiner.

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry Edward Guinn, Sr.			2a. DATE OF DEATH MONTH 12 DAY 26 YEAR 83			2b. HOUR 12 ²⁰ _M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Feb. DAY 16 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Male Nurse -Ret.			12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a. STATE Maryland			13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 544 Monroe Circle 21061		
FATHER'S NAME FIRST Edward MIDDLE G. LAST Guinn					15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Hall						
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Pam Snowden, 853 Turf Valley Drive, Pasadena MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 9110 IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA & HYPOTENSION DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE HEMORRHAGE FROM ESOPHAGUS & STOMACH DUE TO, OR AS A CONSEQUENCE OF (c) TEARS SECONDARY TO CHOKING ON FOOD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James E Taylor					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 12/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E TAYLOR					22e. ADDRESS ST AGNES HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 29 Dec 1983		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie COUNTY AA STATE MD			
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD ADDRESS 						25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE 			

1869

DOWN

20%

UP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alonzo Guyton							2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 5 1983			2b. HOUR M 6P	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept 14 17 66 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 5 1983	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY md. ✓				13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2525 W. Fayette St. 21223			
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Guyton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pydan Fluker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 252-16-0855		17. INFORMANT Edna Guyton				ADDRESS 2525 W. Fayette St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli complicating leg vein thrombosis 8880 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Neck injury DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12/2 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21i. LOCATION STREET CITY OR TOWN COUNTY STATE 2525 W. Fayette St. Baltimore, Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief, MEDICAL EXAMINER				DATE SIGNED 12/6/83			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St.				Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery				23d. LOCATION CITY OR TOWN COUNTY Balto. Md.			
24. FUNERAL DIRECTOR NAME Carlton C. Douglass				ADDRESS 1012 Penn Ave.		25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			



NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

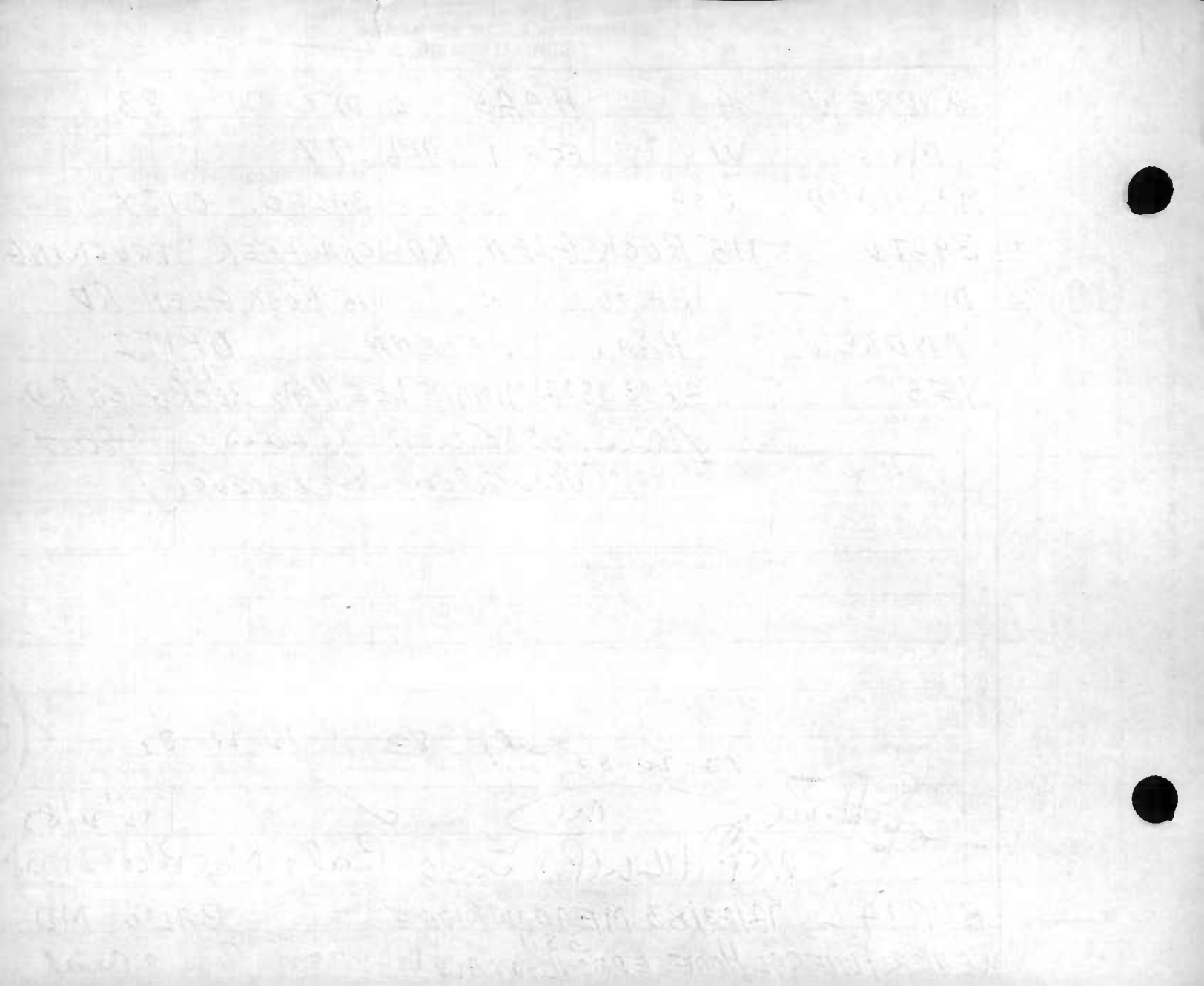
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW A HAAS				2a. DATE OF DEATH MONTH DAY YEAR DEC 21 83		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR FEB 1 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 77		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 ROCK GLEN RD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. STATE M	13b. COUNTY —	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 115 ROCK GLEN RD		
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW HAAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE HELENA DPITZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 216 03 3872		17. INFORMANT ADDRESS MINNIE LEE HAAS 115 ROCK GLEN RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardis- DUE TO, OR AS A CONSEQUENCE OF (b) Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Early 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Early 83 to 12 21 83 , that (I) (we) lost saw the deceased alive on 12-20-83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J MCF HILLIPS		22e. ADDRESS 5550 Balt + Nard Pike 21228				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY MEADENRIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD
24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME		ADDRESS EDMONDSON AVE 5311		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of above.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID W. HAINES			2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 83			2b. HOUR 1240 AM	
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH 3 DAY 23 YEAR 51		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boilermaker		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. 13b. CITY OR TOWN Baltimore 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 6900 Glen Ridge Ct. 3c			
14. FATHER'S NAME FIRST William L. MIDDLE H. LAST HAINES SR.				15. MOTHER'S MAIDEN NAME FIRST Betty MIDDLE Mack LAST Mack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220562382		17. INFORMANT WILLIAM HAINES SR.		ADDRESS 5405 WASENA AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1916 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPSIS, massive G.I. bleeding DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebellar Brain Tumor							
19a. DATE OF OPERATION 10/20/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebellar medulloblastoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-12 , 19 83 , to 12-4 , 19 83 , that (I) (we) last saw the deceased alive on 12-4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David W. Solomon				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Solomon				22e. ADDRESS 225. GREENEST. Balt. md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-8-83		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM.		23d. LOCATION CITY OR TOWN GLEN BURNIE COUNTY A.A. STATE MD.	
24. FUNERAL DIRECTOR NAME BALTO. 21225 GEORGE T. GONCE F.H. 4001 RITCHIE HWY.				25a. DATE REC'D. BY REGISTRAR DEC 5 1983 25b. REGISTRAR'S SIGNATURE John			

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WICKHAMMER SR. 2022 JANUARY 11

(2022)

(INSTRUCTION)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELMER J. HALL, JR.			2a. DATE OF DEATH MONTH DAY YEAR 12/21/83			2b. HOUR 1:00P ^M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8655 Oak Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer J. Hall, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Garrison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. II 220-12-6269		17. INFORMANT Ruth K. Hall 8655 Oak Road 21234			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) circulatory collapse DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction
(c) arteriosclerotic cardiovascular disease 10 yr.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min

5 min

10 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 10</u> , 19 <u>73</u> , to <u>NOV 21</u> , 19 <u>73</u> , that (I) (we) last saw the deceased alive on <u>NOV 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Samuel I. O'Mansky</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>Dec 22 '83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel I. O'Mansky, M.D.				22e. ADDRESS 8405 Loch Raven Blvd. 661-2222			

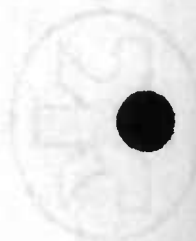
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, '83		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD	
24. FUNERAL DIRECTOR NAME William E. Johnson				ADDRESS 8521 Loch Raven Blvd.		25. DATE REC'D. BY REGISTRAR DEC 22 1983	
26. REGISTRAR'S SIGNATURE <u>John J. Connel</u>							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) GRACE M. HAMMOND			
2a. DATE OF DEATH MONTH DAY YEAR 12 24 83				2b. HOUR 7:25 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6-29-05		6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs. YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13e. STREET ADDRESS 4320 Clareway 21213	
14. FATHER'S NAME FIRST MIDDLE LAST John Killmayer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie McDermott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-22-9466A		17. INFORMANT ADDRESS Grace Berry 4214 Parkside Dr. 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 RESPIRATORY ARREST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYO CARDIAL PNEUMONIA							
(c) DUE TO OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) GASTROESTHETIC HEART FAILURE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 12/24/83 to 12/24/83, that (I) (we) last saw the deceased alive on 12/24/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Marie Amos Dobyns				DEGREE		22b. DATE SIGNED 12/24/83	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) MARIE AMOS DOBYNS				22d. ADDRESS 3015 St. Paul Place, Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL SPECIALLY		23b. DATE 12-28-83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21211				25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE	

RECEIVED BY THE
OFFICE OF THE
ATTORNEY GENERAL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ANNA M. HAMPSON			MONTH DAY YEAR DECEMBER 19 1983			3-10 ^{am}		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MONTH DAY YEAR 6 23 1910		73 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
PENN.	USA.			BALTO CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTO	CHURCH HOSP.			H/W				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY			13c. CITY OR TOWN		
13a. STATE MD.			13b. COUNTY BALTO			13c. CITY OR TOWN EDGEMERE		
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW ALMASY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST — — —					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO —			16b. SOCIAL SECURITY NO. 154-14-8755			17. INFORMANT ADDRESS ERNEST HAMPSON 2507 LODGE FOREST DR. 21219		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from DEC 12 1983, to DEC 19 1983, that (I) (we) last saw the deceased alive on DEC 19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.								
22b. SIGNATURE Paul E. Gormley MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/19/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. GORMLEY MD			22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY BALTO. MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.	
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK			ADDRESS DUNDALK			25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Carver

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN CECILIA HAMRICK			2a. DATE OF DEATH MONTH DAY YEAR 12 18 83			2b. HOUR 10³² PM					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 30 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE MARYLAND			13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2728 E. BALTIMORE STREET, 21224		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GILBERT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY KEATING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-14-4787		17. INFORMANT ADDRESS LILLIAN HUGHES 1605 TREDEGAR AVENUE, 21228						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure - and Cardiac Arrest 2765 DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration and electrolyte imbalance DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raafat Girgis						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raafat Y. Girgis						22e. ADDRESS st. Agnes Hospital Baltimore MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-21-83		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.			23d. LOCATION CITY OR TOWN COUNTY STATE ELK RIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR DEC 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LAWRENCE Bernard HANRATTY Sr.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 25, 1983			2b. HOUR 10:00 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 28 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Truck Driver	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 621 North Kenwood Ave. 21205								
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Hanratty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maila Doenger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 213-03-5526		17. INFORMANT ADDRESS Lawrence B. Hanratty Jr. 4533 Ambermill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 1509 DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC OBSTRUCTION PULMONARY DISEASE								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 5, 1983 to DECEMBER 25, 1983, that (I) (we) lost saw the deceased alive on DECEMBER 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Paul Gormley MD				DEGREE MD		22c. DATE SIGNED 12/28/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL GORMLEY MD.				22e. ADDRESS CHURCH HOSPITAL 100 NORTH BROADWAY BALTIMORE, Md. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-30-83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Balto Co, Md.		
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. 6224 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr		

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE			FIRST ROSE	MIDDLE MARIE	LAST HARBAUGH	2a. DATE OF DEATH MONTH DAY YEAR 12 30 83			2b. HOUR 8:20 A.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 12 28		6. AGE (IN YEARS LAST BIRTHDAY) 55			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MISSIONARY			12b. KIND OF BUSINESS OR INDUSTRY W.E.F.M. MINISTRIES			
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN WOODLAWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7600 CLAYS LANE, APT. 414 21207		
14. FATHER'S NAME FIRST MIDDLE LAST LOYD W. LETTEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLLIE HOLMES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 437-44-6029		17. INFORMANT ADDRESS REV. PAUL HARBAUGH 7600 CLAYS LANE, 21207						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF UNKNOWN PRIMARY 7 MONTHS

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 10/30/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PROLAPSE LAMINECTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/12/83 to 12/30/83, that (I) (we) lost saw the deceased alive on 12/30/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE IAN OLIVER		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IAN OLIVER		22e. ADDRESS UNIVERSITY OF MARYLAND CANCER CENTER 725 GREEN ST. BALTIMORE MD 21209					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-02-84		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENN AVE.				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE, WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

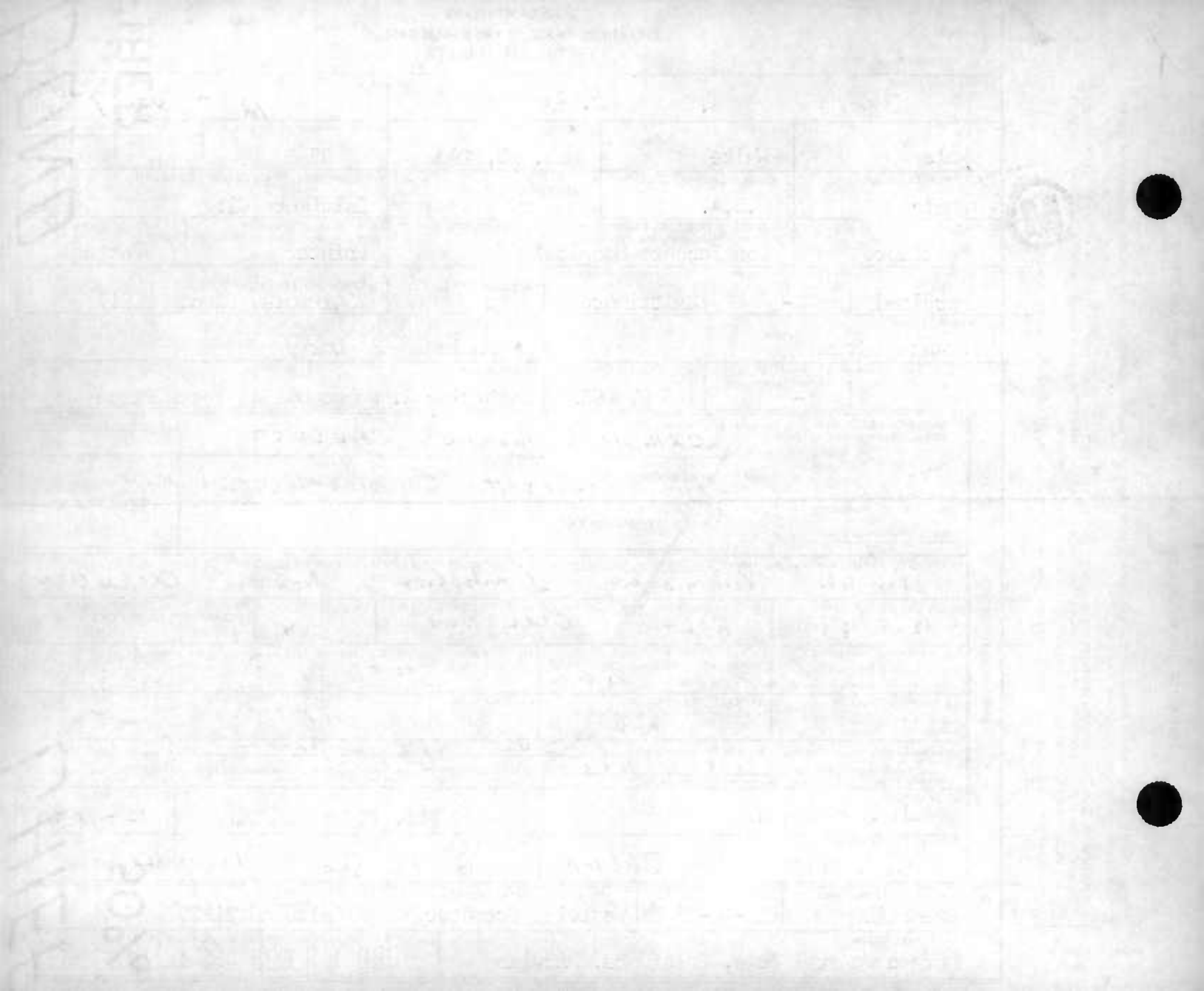
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES R. HARE			2a. DATE OF DEATH MONTH 12 DAY 9 YEAR 83 7b. HOUR 7:40 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Dec. DAY 18 YEAR 1900	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7c. HOUR 7:40 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Painting
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2341 Eutaw Place 21217	
14. FATHER'S NAME FIRST Frank MIDDLE Hare LAST			15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Darby LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 145 07 0983		17. INFORMANT ADDRESS Katherine E. Hopwood 2341 Eutaw Place	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 110. Possible Pulmonary Embolism AORTIC OCCLUSION					
19a. DATE OF OPERATION 12-5-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC OCCLUSION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-4- , 19 83 , to 12-9- , 19 83 , that (I) (we) lost saw the deceased alive on 12-8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Surgeon A. Smith		DEGREE Surgeon		22c. DATE SIGNED 12-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURGIT		22e. ADDRESS JULKA		22f. ADDRESS Bon Sec Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-10-83		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md 21229		23e. DATE REC'D. BY REGISTRAR DEC 12 1983			
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, Baltimore, Maryland ADDRESS		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1000. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS L. HARE			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12-2-83 19			2b. HOUR M M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 31 1921	6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-2-83 19	2d. HOUR 1:37P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2117 Sulgrave Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE Md			13b. COUNTY -----		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Hare			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Palmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-14-5346		17. INFORMANT ADDRESS Brent Hare 2117 Sulgrave Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Margarita A. Korell</u>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 12-2-83		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-83		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.		
24. FUNERAL DIRECTOR NAME Burgee Funeral Home PA. 3631 Falls Rd. 21211				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA FPMR (41 CFR) 101-11.6

REBIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) THOMAS BAKER HARLESS					2a. DATE OF DEATH MONTH 12 DAY 7 YEAR 83				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH May DAY 11 YEAR 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53		7b. HOUR 4:50 MIN P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD			
10. CITY OR TOWN OF DEATH Baltimore city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY General Motors	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1610 Shirley Avenue 21085	
14. FATHER'S NAME FIRST John MIDDLE William LAST Harless				15. MOTHER'S MAIDEN NAME FIRST Nettie MIDDLE Chatam LAST Chatam					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korea 225-38-0355		17. INFORMANT ADDRESS Joppa, Md. 21085 Mrs. Bettie Sue Harless, 1610 Shirley Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute MI, 2 vent. heart 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute pulmonary edema. (c) Diabetes m.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes m.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this) <input checked="" type="checkbox"/> attended the deceased from 12/7 19 83 , to 12/7 19 83 , that (I) (we) last saw the deceased alive on 12/7 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marcos B. Galicia Jr. MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/7/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA Jr. MD						22e. ADDRESS North Charles Gen. Hospital			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Dec. 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event (e.g., medical examination, etc.) must be marked on page 4.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Dec 16 1983

23c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

Maryland

STATE

24. FUNERAL DIRECTOR

NAME

Leonard J. Ruck, Inc. Baltimore, Maryland

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 13 1983

25b. REGISTRAR'S SIGNATURE

John J. Lohr

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32475

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

BERNARD

F.

HARNEK

Sr.

2a. DATE OF DEATH

MONTH

DAY

YEAR

12/12/83

2b. HOUR

10:00 AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

Mar. 14, 1913

6. AGE (IN YEARS LAST BIRTHDAY)

70

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

THE UNION MEMORIAL HOSPITAL

12a. USUAL OCCUPATION

Machinical Engineer Ret.

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4344 Shamrock Ave. 21206

14. FATHER'S NAME

Frank

MIDDLE

LAST

Harnek

15. MOTHER'S MAIDEN NAME

Genieve

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215-05-1455

17. INFORMANT

ADDRESS

Agnes C. Harnek 4344 Shamrock Ave. 21206

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) M.I. (myocardial infarction)

DUE TO, OR AS A CONSEQUENCE OF

(c) CASHO.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

S/p radical cystectomy

19a. DATE OF OPERATION

12/7/83

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Infiltrating bladder Ca.

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M.

MONTH

DAY

YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/6/1983 to 12/12/1983, that (I) (we) lost
saw the deceased alive on 12/12/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

S. Agazarian

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

12/12/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

AGHAZARIAN

SARKIS

22e. ADDRESS

Union Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Dec 16 1983

23c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

Maryland

STATE

24. FUNERAL DIRECTOR

NAME

Leonard J. Ruck, Inc. Baltimore, Maryland

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 13 1983

25b. REGISTRAR'S SIGNATURE

John J. Lohr

March 10 1933

Wilmington, Delaware

Baltimore

Delaware

Dear Sirs:
We have the pleasure to acknowledge the receipt of your letter of March 7, 1933, regarding the matter mentioned above.
We are sorry that we cannot give you a more definite answer at this time, but we are sure that you will understand our position.
Very truly yours,
Leonard J. Cook, Inc.

Enclosed for you are two copies of the report of the committee on the subject of the proposed amendment to the constitution of the State of Delaware.
We are sure that you will find this report of interest.
Very truly yours,
Leonard J. Cook, Inc.

No. 21-05-1355
James C. Harnock 444 Hammond Ave. 2102
Baltimore
Delaware
X
Mar. 14, 1933
Wm. J. Cook, Inc.
Baltimore

Mar. 14, 1933
Wm. J. Cook, Inc.
Baltimore

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY P. HARPER			2a. DATE OF DEATH MONTH DAY YEAR 12 28 83			2b. HOUR 8:45 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 6 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1933 Brady Avenue 21227			
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Woerner, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Phillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 217-01-6271		17. INFORMANT ADDRESS Charles L. Harper 1933 Brady Ave. 21227			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septic Shock

7140

DUE TO, OR AS A CONSEQUENCE OF

(b) Decubitus Ulcers

DUE TO, OR AS A CONSEQUENCE OF

(c) Rheumatoid Arthritis & Malnutrition

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 12/8/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Debridement decubitus ulcers		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2 Dec</u> , 19 <u>83</u> , to <u>28 Dec</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>28 Dec</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David A. Jung		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung, MD.		22e. ADDRESS St. Agnes Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

77

1. DECEASED NAME (TYPE OR PRINT) Bertha Mae Harris			2a. DATE OF DEATH MONTH DAY YEAR 12-23-83		2b. HOUR P.M.						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10-21-1886		6. AGE (IN YEARS LAST BIRTHDAY) 97		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3328 Avondale Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3328 Avondale Ave 21215			
14. FATHER'S NAME FIRST MIDDLE LAST Isaiah Christian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah Page				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 215-09-3461				17. INFORMANT ADDRESS Vincent P. Lee 3328 Avondale Ave.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4254 } DUE TO, OR AS A CONSEQUENCE OF (b) Congestive cardiomyopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/15 , 19 83 , to 12/22 , 19 83 , that (I) (we) last saw the deceased alive on 10/10 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE OLUSEGUN LAWON				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/23/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLUSEGUN LAWON				22e. ADDRESS 200 W Cold Spring Ln, Balt 21210							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md			
24. FUNERAL DIRECTOR NAME ADDRESS Chas. A. Rice FSPA 1300 Eutaw Place				25a. DATE REC'D. BY REGISTRAR DEC 28 1983				25b. REGISTRAR'S SIGNATURE John J. Carroll			

BP

Model **Mean** **SD**

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(continued)

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marie Volk Harris			2a. DATE OF DEATH MONTH DAY YEAR 12 15 83		2b. HOUR 9:00 AM
3. SEX F	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 04 11 26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 57
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y. N.Y.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Anton Volk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gerber		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 077-20-1712		17. INFORMANT ADDRESS 2001 Ben Hill Ave. Mr. James O. Harris, Balto. Md. 21226	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastatic Carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/17 1983 , to 12/15 1983 , that (I) (we) lost saw the deceased alive on 12/15 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Soler				DEGREE Attending Physician	22c. DATE SIGNED 12/15/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Soler				22e. ADDRESS 3001 S Hanover St. Balt., Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-17-1983	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gar.	23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.
24. FUNERAL DIRECTOR James H. 1750 Belton Rd. Kingsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 19 1983	25b. REGISTRAR'S SIGNATURE John J. Under

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

CHILLY



10-11-1962
10-11-1962
10-11-1962

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VENUS HARRIS			2a. DATE OF DEATH MONTH DAY YEAR 12 28 83		2b. HOUR 10:54 AM					
3. SEX Female		4. RACE Blk.		5. DATE OF BIRTH DAY MONTH YEAR 9/7/1898		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Beth.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Md. MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 830 Mt. Holly St.	
14. FATHER'S NAME FIRST MIDDLE LAST James Arthur			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Venus Hansen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-12-6698		17. INFORMANT ADDRESS Hassie Harris-830 Mt. Holly St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Arrest 7070 DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure - Gastrointestinal Bleeding APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30' 12h										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION 12-15-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal Ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/29/83 to 12/28/83 , that (I) (we) lost saw the deceased alive on 12/28/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-28-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DELAZO E. CORREA				22e. ADDRESS LUTHERAN HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23b. DATE 1/3/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR NAME IRVIN CARROLL				ADDRESS 1712 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove stubs on papers. Page 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Joseph Hartman				2a. DATE OF DEATH MONTH DAY YEAR December 28, 1983		2b. HOUR 5:00P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1911		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Electric	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Alphonus Hartman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Weber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Genevieve E. Hartman 21239 Donachie Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Lymphatic Metastases							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 27, 19 83, to December 28, 19 83, that <input checked="" type="checkbox"/> (we) lost the deceased alive on December 28, 19 83, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death.							
22b. SIGNATURE Patricia Weber MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia Weber, M.D.				22e. ADDRESS C/O Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, '83		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD	
24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd.				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Stella J. Hartman			2a. DATE OF DEATH MONTH DAY YEAR 12 29 83			2b. HOUR 6:40PM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 3/22/22		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shamokin, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2851 Chesterfield Ave. 21213				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.			13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Saga			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes (nee Czeck)			13e. STREET ADDRESS / ZIP CODE 2851 Chesterfield Ave. 21213			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS George H. Hartman, same address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Brain Tumor 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION 10/27/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Malignant Brain Tumor			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/20 1983, to 12/29 1983, that (I) (we) lost saw the deceased alive on 12/10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Posey MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/30/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN B. POSEY			22e. ADDRESS 201 E. University Parkway						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/3/84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL HOME NAME ADDRESS Schmunk Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213						25a. DATE RECEIVED BY REGISTRAR DEC 30 1983			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FIBER
DOWN

[Faint, illegible handwriting on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Eugene Harvin				2a. DATE OF DEATH MONTH DAY YEAR 12 20 83			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 20 25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) steelworker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bossie Harvin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Hamnett		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Sept 4, 50			
16b. SOCIAL SECURITY NO. 52217-24-4105		17. INFORMANT ADDRESS Vashti Harvin 735 Linnard St		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 9110 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/20/83 , 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 12 20 83 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. Kusow		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Kusow		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-83		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.	
24. FUNERAL DIRECTOR NAME Brown-Thompson R. H.		ADDRESS 1913 W. Balto. Street		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP _____

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.:

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Joe			Louis			(Haskin)			12 27 83			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Black		7 12 38		45 YRS.		MONTHS DAYS		HOURS MIN.		12 27 1983		2:41A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia				U.S.A.								Baltimore City, MD			
11. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				1505 Federal Street											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
13a. STATE				13b. COUNTY				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1505 E. Federal St. 21213			
Maryland				Baltimore											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				17. INFORMANT			
FIRST MIDDLE LAST				FIRST MIDDLE LAST				(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				ADDRESS			
Lonza				Haskins				YES				Mary Haskins 1505 E. Federal St.			
16b. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
224-46-9317				Mary Haskins 1505 E. Federal St.				PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)				Arteriosclerotic cardiovascular disease				DUE TO, OR AS A CONSEQUENCE OF							
4292				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)							
DUE TO, OR AS A CONSEQUENCE OF				(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				12/28/83			
				M.D. Deputy Chief											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23a. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.				Mount Calvary Cem.				Anne Arundel Co, Md.			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				12/30/83				Mount Calvary Cem.				Anne Arundel Co, Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc.				1101 E North Ave.				DEC 30 1983				John J. Conish			



END

NOV 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CHARLES F HATTON				2a. DATE OF DEATH MONTH DAY YEAR 12-29-83 2b. HOUR 9:33AM			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 31 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U-S-A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3120 HUDSON ST.	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK HATTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES HANNA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS IRENE OLVER 806 S. ROBINSON ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4960 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) COPD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12-29 , 19 30 , to 12-29 , 19 30 , that (I) (we) lost saw the deceased alive on 12-29 , 19 30 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rosita R. Cruz DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-29-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSITA R. CRUZ				22e. ADDRESS GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/1983		23c. NAME OF CEMETERY OR CREMATORY CARLAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO. MD	
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI ADDRESS 2525 FLEET ST.				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward Hawkins			20. DATE KNOWN OF DEATH ESTIMATED XX 12-27 1983			2b. HOUR 7:52 P.M.		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 29 36	6. AGE (IN YEARS) (LAST BIRTHDAY) 47 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 12-27 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Penitentiary				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 954 Forrest St.			21202		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.			16b. SOCIAL SECURITY NO. 217-32-9471			17. INFORMANT Mrs. Karen Hawkins		
16c. ADDRESS Womens Correctional Institution			16d. ADDRESS Jessup Cut, Md. 20794					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 12-28-83		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 5 1984	
					25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			



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U.S. DEPARTMENT OF THE INTERIOR

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DAVID S. BROWN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Albert Hawkins Sr.				2a. DATE OF DEATH MONTH 12 DAY 5 YEAR 83		
1. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH 2 DAY 11 YEAR 06		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkridge, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Field Representative		12b. KIND OF BUSINESS OR INDUSTRY National AFL-CIO		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY Balto. Co. 12c. CITY OR TOWN Halethorpe		
13a. STREET ADDRESS / ZIP CODE 4309 Spencer St. - 21227		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 4309 Spencer St. - 21227		
14. FATHER'S NAME FIRST Robert MIDDLE Hawkins LAST Hawkins		15. MOTHER'S MAIDEN NAME FIRST Georgianna MIDDLE Johnson LAST Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO. 215 09 4788		17. INFORMANT Mrs. Amy J. Hawkins - 4309 Spencer St.		ADDRESS 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 2041 DUE TO, OR AS A CONSEQUENCE OF (b) Severe Anaemia, Myocardial Infarction ? DUE TO, OR AS A CONSEQUENCE OF (c) CLL					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Lymphocytic Leukaemia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12.4.83 , 19____, to 12.5.83 , 19____, that (I) (we) lost saw the deceased alive on 12.5.83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Purushottam Mitra		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12.5.83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Purushottam Mitra		22e. ADDRESS St. Agnes Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md.		23e. DATE REC'D. BY REGISTRAR DEC 6 1983		23f. REGISTRAR'S SIGNATURE John J. Carver		
24. FUNERAL DIRECTOR Nutter and Sons		2501 Gwynns Falls Pk- ADDRESS wy., Balto. Md. 21216		25. DATE REC'D. BY REGISTRAR DEC 6 1983		

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Robert

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 4 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNIE B. HAYES			2a. DATE OF DEATH MONTH DAY YEAR 12/31/83			2b. HOUR 5:08 PM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST James White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1300 E. Lanvale St. 21213		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Donald G. Hayes 1823 East 33rd St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>12/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. E. Turianno				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/31/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. E. Turianno				22e. ADDRESS UNION MEMORIAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/6/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION Baltimore, COUNTY MD.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE J. C. C. C.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST Clifford M Hayes Jr		MONTH DAY YEAR 12 28 83		M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 21 28		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portsmouth, Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) binder		12b. KIND OF BUSINESS OR INDUSTRY Council press	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clifford M Hayes Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice B Kelly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 281 22 1644	
		17. INFORMANT ADDRESS Carol J. Hayes 1821 Walnut Avenue 21222					
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute myocardiac infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>4/24</u> , 19 <u>81</u> , to <u>2/2</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>A.F. Nour</i>		22c. DATE SIGNED 12/29/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.F. Nour, M.D.		22e. ADDRESS 1576 Merritt Blvd. Ste #9					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Walter Dabrowski		ADDRESS 1005 Dundalk Avenue		25a. DATE REC'D. BY REGISTRAR JAN 03 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
MARY B. HAYES		12/27/83		5:22 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	86 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD	USA		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	UNION MEMORIAL HOSPITAL	Asst. Manager	Apartments		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3925 Beech Ave., 21211	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
William Young Ballew		Mary Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217 34 6765		Bradley Mettee, Balto., MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac arrest					25 mins
5602 DUE TO, OR AS A CONSEQUENCE OF					< 1 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypoxia					
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure or sepsis					2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
COPD, Abdominal surgery					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
12-23-83	Acute abdomen - bowel volvulus	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M.				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1983, to 12/27, 1983, that (I) (we) last saw the deceased alive on 12/27, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE			22c. DATE SIGNED	
James D. Spearman	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
JAMES D. SPEARMAN	UNION MEMORIAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	12/29/83	Druid Ridge	Pikesville,		MD
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Henry W. Jenkins & Sons Co.			DEC 29 1983	James J. Connel	
4905 York Road Balto., MD 21212					

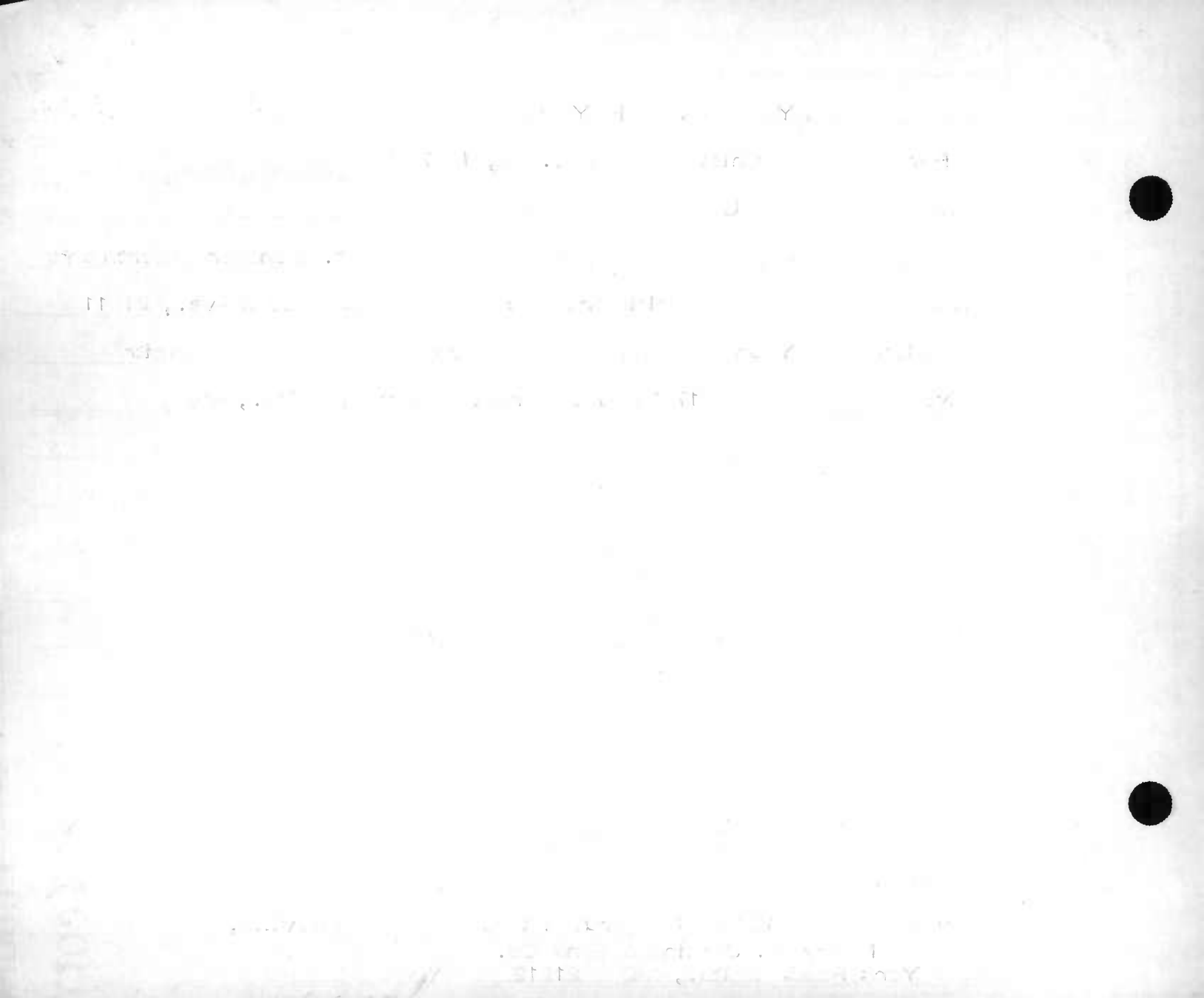
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DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 above, injury, or other traumatic event, the medical examiner must be notified at once.



ONE-25

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

8 208 56 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. This certificate is to be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 1 of 2. This certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Wayne Preston Hays			2a. DATE OF DEATH MONTH DAY YEAR 12-23-83			2b. HOUR 6:10P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer		12b. KIND OF BUSINESS OR INDUSTRY Census Bureau	
13a. STATE Maryland			13b. COUNTY Pr Geo		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John F. Hays			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn R. Hill			13e. STREET ADDRESS / ZIP CODE 8106 Holiday Ave. 20744			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Viet Nam 218-52-5948		17. INFORMANT Mary C. Hays		ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) small cell anaplastic carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 4 months 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) radiation pneumonitis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (This hospital) attended the deceased from 12/15 , 19 83 , to 12/23/ , 19 83 , that (I) (we) lost saw the deceased alive on 12/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. M. Hines			DEGREE M.D., Ph.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. Hines			22e. ADDRESS Johns Hopkins Hospital BALTIMORE MARYLAND 21205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-28-83		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm			ADDRESS Suitland, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 29 1983				

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 will be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Pete Hazel					2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 83 2b. HOUR 8:30PM				
3. SEX M		4. RACE B		5. DATE OF BIRTH MO 7 DAY 17 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1206 N. Wolfe St. 21213	
14. FATHER'S NAME FIRST Buck MIDDLE LAST Hazel					15. MOTHER'S MAIDEN NAME FIRST Mollie MIDDLE LAST <input checked="" type="checkbox"/>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. 215-16-9969		17. INFORMANT Celia Hazel ADDRESS 1206 N. Wolfe Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardio-Respiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerotic C-V disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Ischemic, Granulomatous bowel disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-11-83 , to 12-12-83 , that (I) (we) last saw the deceased alive on 12-12-83 , and that in (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.									
22b. SIGNATURE Jami Punsalan					DEGREE			22c. DATE SIGNED 12/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 12/16/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA			23d. LOCATION CITY OR TOWN Owning Mills, COUNTY Md. STATE		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue ADDRESS					25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25. REGISTRAR'S SIGNATURE John J. Connel		

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		2b. HOUR	
PHILLIP A. HEILKER		12 - 6 - 83		11 ³⁰ P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	2 MONTH 23 DAY 07 YEAR	76 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE UNION MEMORIAL HOSPITAL		Welder		Railroad
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.		Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
Clement		Teresa		2918 N. Calvert St. 21218	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		214-18-9236		3701 Roland Ave. Ms. Helen Frederick Balto., Md. 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Congestive heart failure ; pleural effusion</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 months
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>83</u> , to <u>12-6</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
JH Townsend M		MD		12-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
F J TOWNSEND MD		Union Memorial Hosp 201 E. Univ Pkwy			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		12/8/83			
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
		DEC 19 1983			
24. FUNERAL DIRECTOR NAME		ADDRESS		25b. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		John J. Connel	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene. If the deceased was cremated, or removed to another place of interment, the funeral director must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) BABY GIRL HEINE			2a. DATE OF DEATH MONTH DAY YEAR 12/25/83		2b. HOUR 3:45pm	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 12 21 1983		6. AGE (IN YEARS LAST BIRTHDAY) 4		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE Md.		13b. COUNTY Baltimore		13c. STREET ADDRESS / ZIP CODE 3 S. Collington Ave. 21231		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Heine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Michelle Lindamood				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Michelle Heine 3 S. Collington Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 7515 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CLOACAL EXSTROPHY						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from DEC 21 19 83 , to DEC 25 19 83 , that (1) (we) lost saw the deceased alive on DEC 25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Daniel A. Goldstein		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL A. GOLDSTEIN		22e. ADDRESS JOHNS HOPKINS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/83		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.		24b. DATE REC'D. BY REGISTRAR JAN 03 1984		24c. REGISTRAR'S SIGNATURE John J. Conner		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
LOUIS W. HEINZENBERGER				December 14, 1983				4:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		July 16, 1910		73		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		806 Unetta Avenue				Retired		Balt. City	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS			
Maryland				Baltimore		806 Unetta Avenue 21229			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
William Heinzenberger				Louise Kroney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes WW 1				217-26-7448A		1029 R10 Lane Anne S. Hesh Severna Park, Md. 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> (b) <u>Cirrhosis of liver</u> (c) <u>alcoholism.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED
22b. SIGNATURE <u>Nayan Vaywala MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									12/15/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Nayan Vaywala M.D.				St. Agnes Medical Center-Suite 301 3455 Wilkens Avenue, Baltimore, Md. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/17/83		Loudon Perk Cemetery		Baltimore Md.			
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR					
Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				DEC 16 1983					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8 3 3 2 4 2 5			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Louise HELLER				2a. DATE OF DEATH MONTH DAY YEAR December 23, 1983			
3. SEX Female				2b. HOUR 2:50A			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 27 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 years		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Schwarz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie		17. HOME ADDRESS 827 Linden Ave., Balto., MD. 21201			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-12-6582		17. ADDRESS Maryland General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metastatic Carcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 5, 1983 , to December 23, 1983 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 23, 1983 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE Patricia A. Weber MD				DEGREE MD		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. WEBER MD				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 03 1984	
				25b. REGISTRAR'S SIGNATURE John J. Connel			



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Letter to General MacArthur c/o

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) LEONARD RAY HENDERSON, JR.						2a. DATE OF DEATH MONTH DAY YEAR 12/06/83			2b. HOUR 10 A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 16 25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofing Bus.		12b. KIND OF BUSINESS OR INDUSTRY Roofing-			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3407 Benson Avenue 21227			
4. FATHER'S NAME FIRST MIDDLE LAST Leonard R. Henderson, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 218-14-7266		17. INFORMANT ADDRESS 21227 Leonard R. Henderson, III 3407 Benson Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electromechanical Dissociation</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE ANTEROSEPTAL MYOCARDIAL INFARCTIONS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Coronary Vessel Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DIABETES mellitus.</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> 19 <u>79</u> to <u>December 6</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec. 6</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. N. M. Machiran</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. N. M. MACHIRAN				22e. ADDRESS 4713 Leeds Ave, Arbutus, Md, 21227							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR 21229 DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALICE D. HENNEGAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983			2b. HOUR 6 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 5, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LONG GREEN NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEVER WORKED	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD.							
13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6404 PRATT AVE. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST AUGUST HENNEGAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE RYAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-42-9857T		17. INFORMANT ADDRESS MRS. KEVIN MULLER 6404 PRATT AVE. 21212			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4409

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

*Congestive heart failure
Arteriosclerosis*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 12</i> 19 <i>83</i> to <i>Dec 24</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Dec 24</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (we did not) view the body after death.							
22b. SIGNATURE <i>William G. Helfrich MD for Norman Freeman</i>				22c. DATE SIGNED 12/24/83		22d. ADDRESS 5006 ROLAND AVE.	
22e. ADDRESS				22f. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 03 1984 <i>Jan J. Canine</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF TEXAS

COUNTY OF _____



[Faint handwritten text]

[Faint handwritten text]

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[Faint handwritten text]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE HENRY LAST			2a. DATE OF DEATH MONTH DAY YEAR 12/10/83		2b. HOUR 12:00A
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH DAY YEAR 4 10 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 204 N. Washington St.
14. FATHER'S NAME FIRST Edward MIDDLE Collins LAST			15. MOTHER'S MAIDEN NAME FIRST Bernetta MIDDLE Ford LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Father Harris 1628 E. Lanvale St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1179 IMMEDIATE CAUSE (a) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

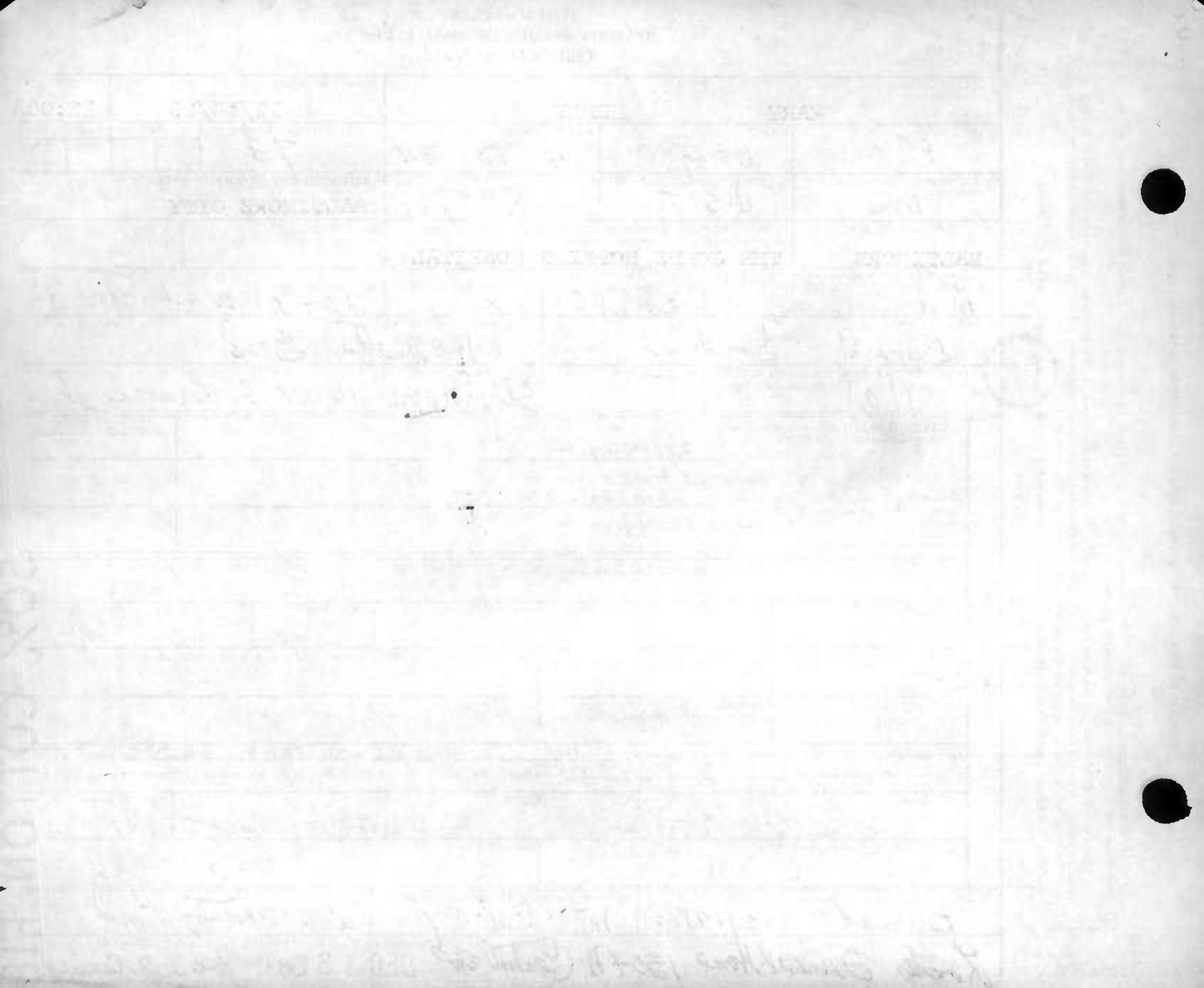
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/11, 1983, to 12/10, 1983, that (I) (we) lost saw the deceased alive on 12/19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE George Bittan	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/10/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Bittan		22e. ADDRESS Johns Hopkins	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/14/83	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION CITY OR TOWN COUNTY STATE A.D. County MD
24. FUNERAL DIRECTOR NAME Locke Funeral Home 1304 N. Central St		25a. DATE REC'D. BY REGISTRAR DEC 13 1983	25b. REGISTRAR'S SIGNATURE John J. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the police must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the removal of the body to the funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.					
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL E. HEPLER						12 30 83				M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 8 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4235 ROKEYB ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4235 Rokeby Road 21229			
14. FATHER'S NAME FIRST MIDDLE LAST William E. Hepler						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Hoskins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-03-4866A		17. INFORMANT ADDRESS Lillian Hepler 4235 Rokeby Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2500 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DIABETES mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 immediate years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gray G. Haber MD								DEGREE MD		22c. DATE SIGNED 1/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gray G. Haber MD								22e. ADDRESS Univ. of MD Hospital 22 S. Green ST			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/6/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			

MEDICAL CERTIFICATION



George H. White

Attorney at Law

General Counsel

John H. White

Attorney at Law

General Counsel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Raymond Henry Hess		12-28-83		9:18 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	54 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALT CITY		North Charles General Hospital		Polisher	
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS	12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		Baltimore	Essex 21221	Steel Co.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
August Hess		Caroline Ryder		13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
Yes		1951-53	Margaret Hess (wife)		Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
1719					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) Sepsis					
DUE TO, OR AS A CONSEQUENCE OF					
Mal. Placochistocytoma, reboxipolomina					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
11/24/83		Intra-abdominal tumor		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 9:18 AM 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/16/83, to 12/28/83, that (I) (we) lost saw the deceased alive on 12/28/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Joe T.P. Ruiz		M.D.		X	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Joe T.P. Ruiz		North Charles General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/31/83		Parkwood Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE			
Baltimore County Maryland		John J. Conner			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			
Bruzdinski Funeral Home PA 1407 Old Eastern Ave		DEC 30 1983			

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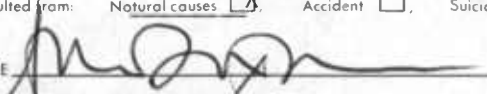

100-100000

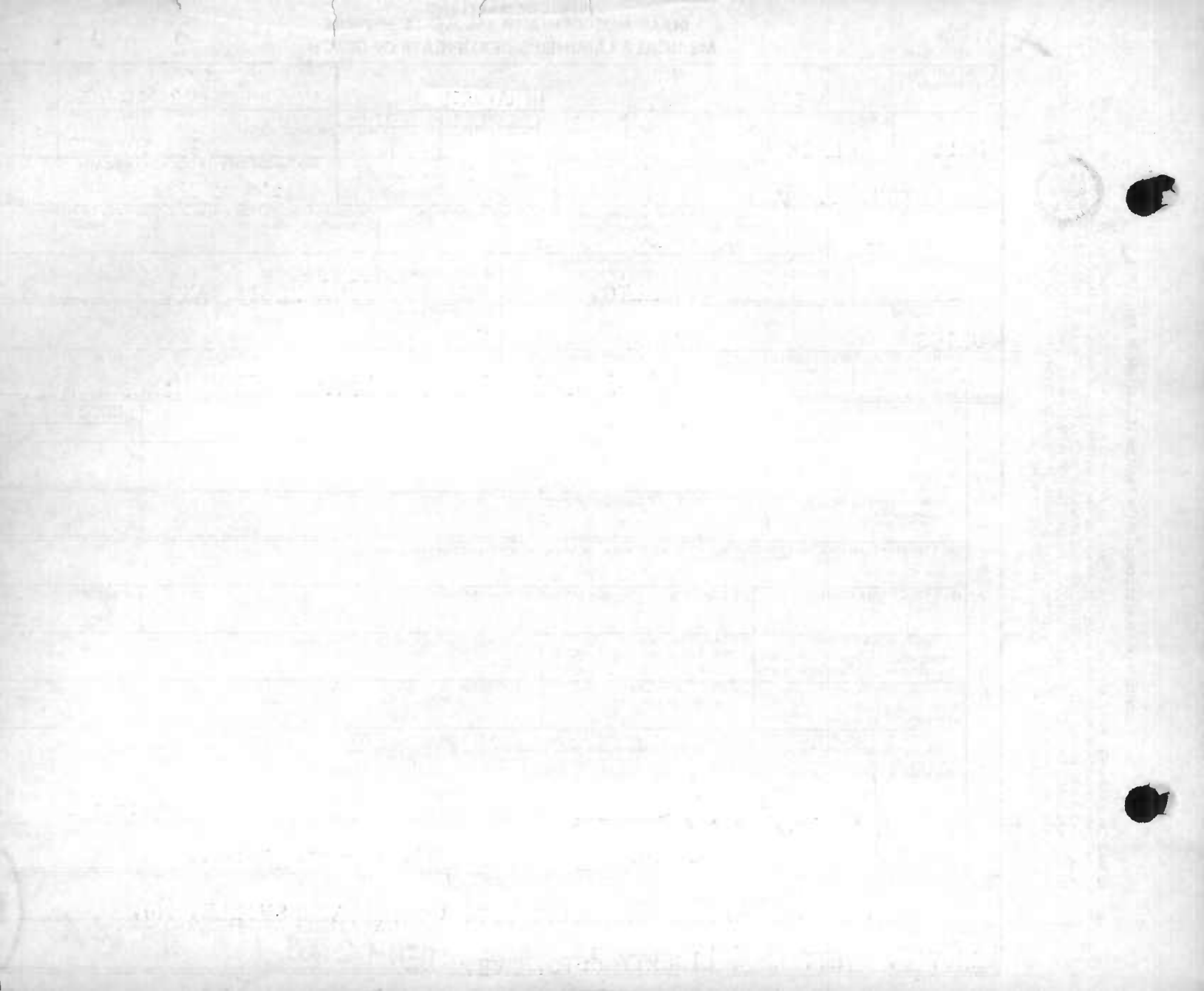
100-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 7. IF THE DEATH OCCURRED AT A FUNERAL HOME, GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. IF THE DEATH OCCURRED AT A HOME, GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. IF THE DEATH OCCURRED AT A HOME, GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. IF THE DEATH OCCURRED AT A HOME, GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32501	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES J. HEYWARD										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 10 1983	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 17 26 57		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. YRS.		7c. DATE PRONOUNCED DEAD 12 10 1983		2b. HOUR 4:05 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHARLSTON, S. CAR.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY BALTO.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3301 ELGIN AVE. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS HEYWARD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 216-20-9814		17. INFORMANT ADDRESS BERNICE HEYWARD 3308 WINDSOR AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 12-11-83		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VET. CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE, MD.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT						ADDRESS 4600 LIBERTY Hgts. Ave.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARNETT (Cornett) Higgs Jr.			2a. DATE OF DEATH MONTH DAY YEAR 12 27 83		2b. HOUR M AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 18 05	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 633 N. Aisquith St. Apt. 16A		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 633 N. Aisquith Street 2120	
14. FATHER'S NAME FIRST MIDDLE LAST Carnett Higgs, Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-03-5023		17. INFORMANT ADDRESS Lucy Fields' 1100 Pennsylvania Ave. Apt. 208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 7, 1983 , to October 5, 1983 , that (I) (we) lost saw the deceased alive on October 13, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gina Dallabetta		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gina Dallabetta		22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		23e. DATE REC'D. BY REGISTRAR DEC 29 1983			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph HILL			2a. DATE OF DEATH MONTH DAY YEAR December 16, 1983			2b. HOUR A 4:40 M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 6 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 711 N. Carey Street 21223	
14. FATHER'S NAME FIRST MIDDLE LAST John Hill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Rose Spence 711 N. Carey Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Pneumonia IMMEDIATE CAUSE (a) 1991 DUE TO, OR AS A CONSEQUENCE OF Metastatic Carcinoma to the Liver (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 4 , 19 83 , to December 16 , 19 83 , that xx (we) lost saw the deceased alive on December 16 , 19 83 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) (did) (do not) view the body after death.										
22b. SIGNATURE Kuo-Liang Huang			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kuo-Liang Huang M.D.			22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

4-40

December 16, 1983

WILL

Joseph

Baltimore City

Harvard General Hospital

Baltimore

Pneumonia

Metastatic Carcinoma to the Liver

x

x

rx

December 16, 83

83

December 4

83

December 16

x

xxx

12/16/83

c/o Harvard General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

Item #6 G586 12/29/83 CW				STATE OF MARYLAND			
DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) PAULINE V. HILL				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 2, 1983		2b. HOUR 12:41^P	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 18 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE M.D.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Burrier Hill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Roberts		13e. STREET ADDRESS 3214 Massachusetts Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 3214 Massachusetts Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7464 Ventricular fibrillation		DUE TO, OR AS A CONSEQUENCE OF (b) Aortic stenosis		DUE TO, OR AS A CONSEQUENCE OF (c) bicuspid aortic valve			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary edema, H/o hyperthyroidism							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 1, 1983 to December 2, 1983 , that (I) (we) last saw the deceased alive on Dec 2, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (we) did not view the body after death.)							
22b. SIGNATURE R. Roubenoff MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R ROUBENOFF		22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-83		23c. NAME OF CEMETERY OR CREMATORY Abutus Men. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Vernon R. Baliey ADDRESS 1348 Calhoun St.				25a. DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

2026 OCT 04

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA S. HILL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1983			2b. HOUR P. 10:00				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 07 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 10:00		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Delaware			13b. COUNTY Sussex		13c. CITY OR TOWN Selbyville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rte #1 Box 1220 99999	
14. FATHER'S NAME FIRST MIDDLE LAST George Smullen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roxie Phippin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 125-03-4355		17. INFORMANT ADDRESS Mr. Benson W. Davis 15016 Nashua Lane, Bowie, Md. 20716					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

0389

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutesConditions, if any, which
gave rise to immediate
cause: (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ARDS****1 HR**

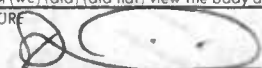
DUE TO, OR AS A CONSEQUENCE OF


(c) **SEPSIS AND PNEUMONIA****DAYS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

LUNG CANCER

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8 Dec , 19 83 , to 8 Dec , 19 83 , that (I) (we) last saw the deceased alive on 8 Dec , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE MD PhD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-8-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONNA PRZEDIORKA		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE, BALTIMORE, MD 21205					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/1983		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION Salisbury Wicomico Maryland	
24. FUNERAL DIRECTOR Hoffoway Funeral Home, P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE 	

Holloway Funeral Home, P.A. Salisbury, Md.

Burial

12/13/1993

Parsons Cemetery

Salisbury

Salisbury Wisconsin Maryland



125-03-4355 1516 Washington Lane, Bowie, Md. 20716

Mr. Benson W. Davis

Florida

George

London

Wexie

Rte W Box 1220

Delroyville

Sussex

Delaware

Houswife

THE JOHN HONOR B. HOSPITAL

WASHINGTON

Maryland

U.S.A.

x

11 07 1993

21

Female

White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROMAN LAWRENCE HNAT			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1983		2b. HOUR 8:57a _M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1896		
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland		15b. COUNTY Baltimore		15c. CITY OR TOWN Lansdowne		
16. FATHER'S NAME FIRST MIDDLE LAST John S. Hnat		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonia Mach		18. STREET ADDRESS 223 Clyde Avenue (21227)		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I 218 12 4401		21. INFORMANT (daughter) Mrs. Shirley Kraeger ADDRESS Linthicum, Maryland 21090		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) INTRACTABLE CARDIAC DYSFUNCTION

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

ACUTE RENAL FAILURE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec 13, 19 83, to Dec. 20, 19 83, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Dec. 20, 19 83, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE Steven A. Henry MD				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN A HENRY MD				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME R. E. Hopson Singleton Funeral Home Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST JULIA	MIDDLE ELIZABETH	LAST HOFFMEISTER	MONTH DAY YEAR DECEMBER 16, 1983			11:00 pm		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1/1/1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4603 CROSSWOOD ROAD 21214			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE PETER MEYER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH HORNEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212.56.4643		17. INFORMANT ADDRESS RAYMOND B. HOFFMEISTER SAME AS 13e.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5-15 min

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

DIABETES MELLITUS

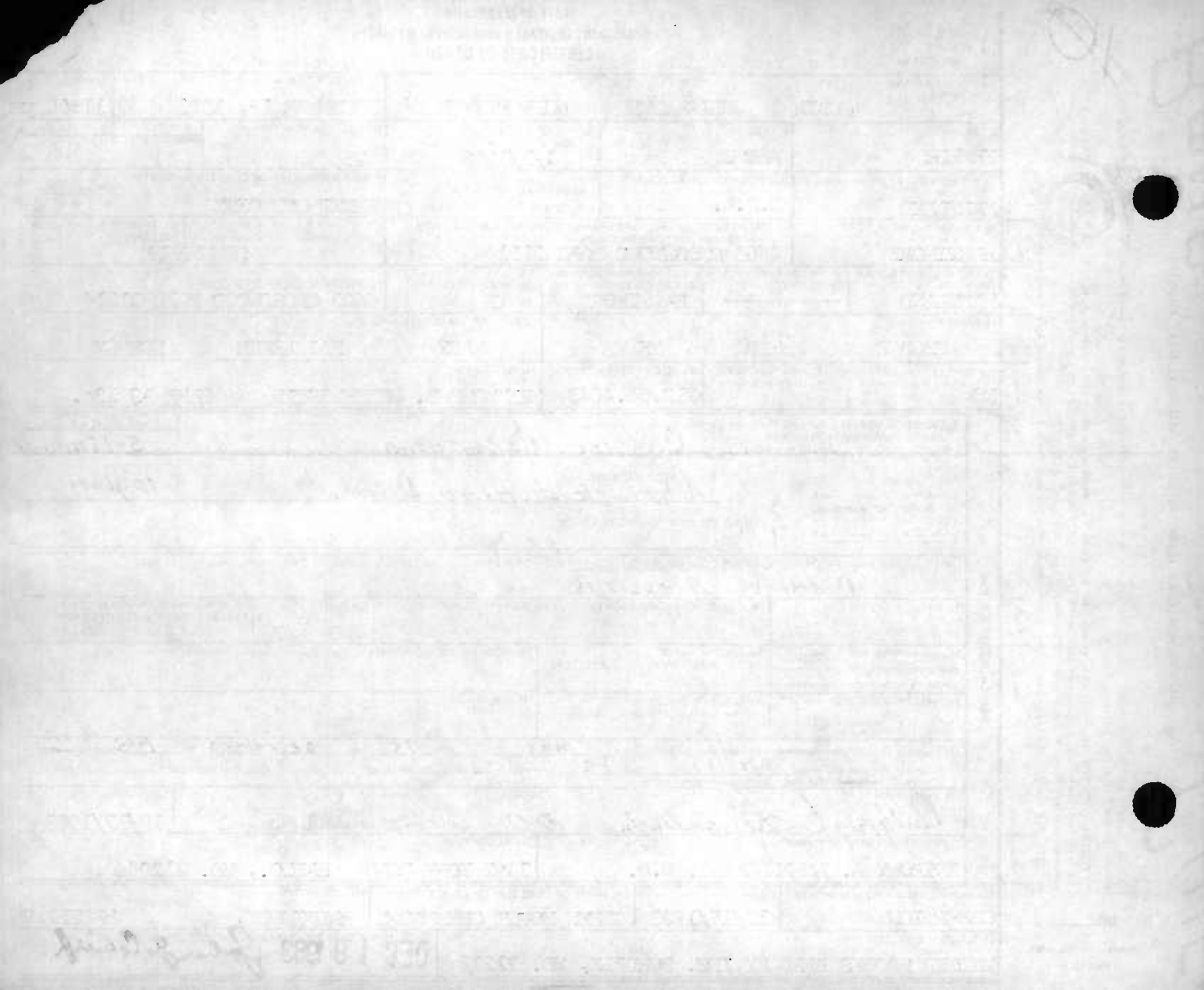
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 19 73, to DECEMBER 19 1983 that (I) (we) last saw the deceased alive on NOV 1 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Anthony C. Lewandowski M.D.				DEGREE M.D.		22c. DATE SIGNED 12/17/1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY A. LEWANDOWSKI, M.D.				22e. ADDRESS 7402 YORK ROAD BALTO., MD. 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12/17/1983	23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222		25. DATE REC'D. BY REGISTRAR DEC 19 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank Holy			2a. DATE OF DEATH MONTH DAY YEAR 12-31-83			2b. HOUR 7:35 P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 20 00		6. AGE (IN YEARS LAST BIRTHDAY) 83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Maker		
12b. KIND OF BUSINESS OR INDUSTRY Shoe Factory								
13a. STATE MD			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1213 Light St 21201								
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1919-1921		17. INFORMANT Baltimore, Md. 21208 Charles F. Blum Jr. 5438 Old Court Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Ventricular ectopy DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) S/P myocardial infarction								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-23 , 19 83 , to 12-31 , 19 83 , that (I) (we) last saw the deceased alive on 12-31 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Jeanne Saunders MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-31-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeanne Saunders		22e. ADDRESS 301 St Paul Place Mercy Hosp						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL HOME NAME ADDRESS Schumaker Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE Jeanne Saunders		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

THE UNIVERSITY OF CHICAGO
LIBRARY

Handwritten notes on lined paper, including a table at the top and several paragraphs of text. The handwriting is cursive and somewhat faded.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
FIRST MIDDLE LAST Samuel Preston Holder III		MONTH DAY YEAR 12-14 1983		MONTH DAY YEAR 12-14 1983	
3. RACE White		4. DATE OF BIRTH MONTH DAY YEAR 4 25 62		5. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.	
6. SEX Male		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock & Deliveries		12b. KIND OF BUSINESS OR INDUSTRY Newspaper		13a. STATE Md	
13b. COUNTY =====		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Preston Holder Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Lam		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 213-88-7103		17. INFORMANT Samuel P. Holder Jr.		17e. ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head (Unspecified) 9654 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:50 PM 12-14 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1000 blk. Leadenhall St., Balto., Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 12-14-83	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS 4001 Ritchie Hgwy Balto, Md		25. DATE REC'D. BY REGISTRAR DEC 19 1983	
25. REGISTRAR'S SIGNATURE John J. Connelley		COUNTY A.A. STATE Md			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be returned to the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gwendolyn RYCE 4 Holley			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1983		2b. HOUR 09:40AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 3 83	6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 2 2		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 208 Fleming Drive 21222		
14. FATHER'S NAME FIRST MIDDLE LAST James I. Holley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Sharon Thompson 7409 Alvah Ave. Apt. J		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7589 IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congenital brain anomalies</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>abnormal chromosome 15</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 3 months 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> , 19 <u>83</u> , to <u>12/24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Patricia A Tewes MD				DEGREE MD		22c. DATE SIGNED 12-24-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia A Tewes MD				22e. ADDRESS 600 N. Broadway Baltimore MD Dept of Neurology Johns Hopkins Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/28/83	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE John J. Connel

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Avon HOLLMAN			2a. DATE OF DEATH MONTH DAY YEAR 12 19 83		2b. HOUR 10:15 P.M.
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 7 37	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Walter D. Hollman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Paige		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-32-3662	17. INFORMANT ADDRESS Katherine Bonner 1826 E. 28th Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 5120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung abscess - 2nd rib respiratory disorder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>syncope - Bilelental pneumonia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE PAM MD		DEGREE		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAN BUI MD		22e. ADDRESS Provident Hospital			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/23/83	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 North Avenue			25. DATE REC'D. BY REGISTRAR DEC 21 1983		
26. REGISTRAR'S SIGNATURE John J. Connel					



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08054935013ME221228
315 INGLESIDE AVE.

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEN HOPES			2a. DATE OF DEATH MONTH DAY YEAR 12-11-83			2b. HOUR 8:50 M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 20 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2121 Windsor Garden Lane 21207	
14. FATHER'S NAME FIRST MIDDLE LAST James F. Hopes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Galbreath							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-14-9467		17. INFORMANT ADDRESS Mary C. Hopes 2121 Windsor Garden La					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a UREMIA										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from 12-6-83 , to 12-11-83 , that (we) lost saw the deceased alive on 12-11-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. K. THUNGAM MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-11-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. K. THUNGAM MD					22e. ADDRESS North Charles General Hospital					
23a. BURIAL, CREMATION, REMOVAL (S) BURIAL			23b. DATE 12/16/83		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN Baltimore, COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue					25a. DATE RECD. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Carney			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7

DATE	TIME	PLACE
10-11-55	10:00	...
10-12-55	10:00	...
10-13-55	10:00	...
10-14-55	10:00	...
10-15-55	10:00	...
10-16-55	10:00	...
10-17-55	10:00	...
10-18-55	10:00	...
10-19-55	10:00	...
10-20-55	10:00	...
10-21-55	10:00	...
10-22-55	10:00	...
10-23-55	10:00	...
10-24-55	10:00	...
10-25-55	10:00	...
10-26-55	10:00	...
10-27-55	10:00	...
10-28-55	10:00	...
10-29-55	10:00	...
10-30-55	10:00	...
10-31-55	10:00	...

15th Nov 1955
A. J. ...
...

1955



CHIEF

FOR COLON

1955
...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 5 1 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARK E. HORAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 12, 1983			2b. HOUR 4:30 A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 2 55		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Tech.		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse B.W.I.	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Horan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Ogradowska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 190-46-2098		17. INFORMANT ADDRESS Janet L. Horan 231 S. Calhoun St. 21223			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **respiratory arrest**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2089
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **acute biphenotypic leukemia**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

renal failure. Hepatic dysfunction Seizures

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 4, 1983 to December 12, 1983 , that (I) (we) lost saw the deceased alive on December 12, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Susan K. Ferrand				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ferrand				22e. ADDRESS 600 N. WOLFE ST. BALTO. MD. Johns Hopkins Hospital 21205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/16/83	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
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24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.	24b. ADDRESS 4107 Wilkens Ave.	25. DATE REC'D. BY REGISTRAR DEC 14 1983	26. REGISTRAR'S SIGNATURE John J. Carver
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21e is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Lenora I. Horton</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 21 83</i> 2b. HOUR <i>5²⁵ P M</i>			
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 29 38</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>45</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John Deaton Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Williams</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Moore</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>218-36-6489</i>		17. INFORMANT ADDRESS <i>Mary Ballard 1023 N. Washington St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: <i>4039 Renal Failure</i> IMMEDIATE CAUSE (a) <i>Hypertension & Diabetes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>X</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>X</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>X</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>NO</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>12/14/83</i> to <i>12/21/83</i> , that (we) lost <i>saw the deceased alive on 12/21/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J.P. Gladue, M.D.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12/22/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (S) <i>BURIAL</i>		23b. DATE <i>12/28/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Auburn Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Wm C March F/H Inc, 1101 E, North Ave,</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 23 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

BP

General Failure
Hypertension, Diabetes, X-ray

PO% CO2 100



PA. Blotter, 100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doratheia A. Howard				2a. DATE OF DEATH MONTH DAY YEAR 12 14 83			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 6 1918		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 8412 Kavanagh Road 21222			
14. FATHER'S NAME FIRST MIDDLE LAST Not Known Kuhns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 170-09-9969		17. INFORMANT Donald F. Howard		ADDRESS 506 S. Lehigh St. Balto., MD. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a). <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>CHF, Pneumonia, ascites</u> DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from 11/10 to 12/13, 1983, that (I) (we) lost saw the deceased alive on 12/14/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. F. D. Nardo				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. F. D. Nardo MD				22e. ADDRESS Baltimore City Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/1983		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE RECEIVED BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

19 11 41

25

Handwritten notes and tables on lined paper. The text is mostly illegible due to fading and bleed-through. Some visible fragments include:

- Top left: "19 11 41"
- Top right: "25"
- Center: "The following table shows the results of the experiment..."
- Bottom: "The results of the experiment are as follows..."



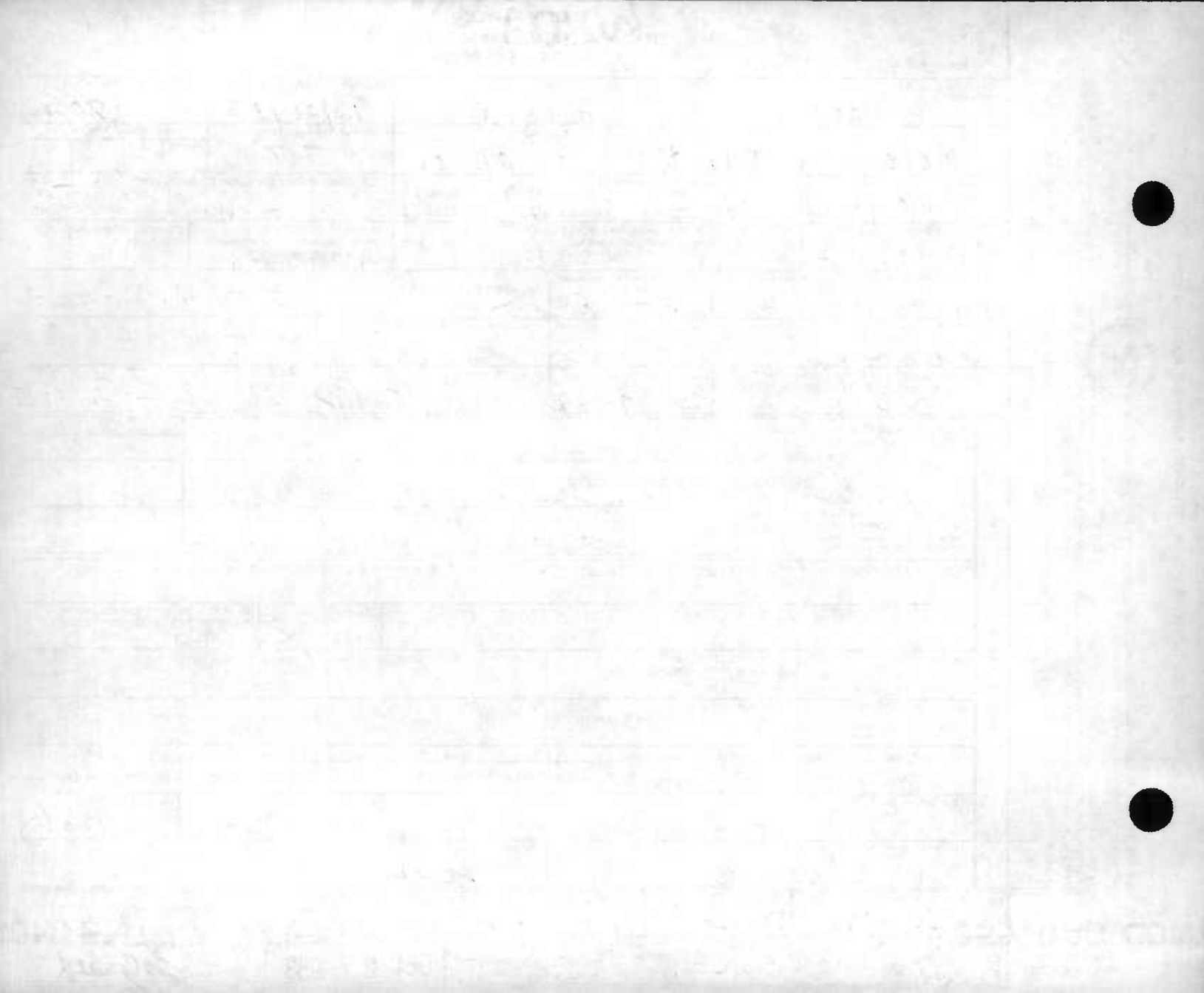
TO HOSPITAL/WORK ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				12/20/83				7:05 AM			
3 SEX				4 RACE				5. DATE OF BIRTH MONTH DAY YEAR			
Male				Black				3 21 06			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				6 AGE (IN YEARS LAST BIRTHDAY)			
Maryland				U.S.				77 YRS.			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				9 BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore				City Hospital				Baltimore city MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				13a. STREET ADDRESS			
Retired								1422 E. Oliver Street			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN			
Maryland				Baltimore				Baltimore			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
George Waters				Louise ?				NO			
16b. SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
705-07-7896				Russell Biddle				1422 E. Oliver Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1850 IMMEDIATE CAUSE (a) Respiratory Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Lower extremity ischemia											
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic prostate carcinoma											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/19/83 to 12/20/83, that (we) last saw the deceased alive on 12/19/83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
B W Wolock, MD								12/20/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
B Wolock				Beth							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				Dec. 24, 83				Mt. Auburn			
23d. LOCATION CITY OR TOWN				23e. COUNTY				23f. STATE			
Baltimore				Baltimore				Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
Brown-Thompson				1918 W. BALD. ST.				DEC 27 1983			
								25b. REGISTRAR'S SIGNATURE			
								John J. Carrier			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W. Hudnall			2a. DATE OF DEATH MONTH DAY YEAR 12 4 83		2b. HOUR 4:30pM
3. SEX M.	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 9 14 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baito	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. Agnes		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. CITY OR TOWN Baito	13c. STREET ADDRESS / ZIP CODE 910 Allendale St. 21229	
14. FATHER'S NAME FIRST MIDDLE LAST Walter E. Hudnall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW11 218-03-4350		17. INFORMANT ADDRESS Bernard W. Hudnall 910 Allendale	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 5789 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c) duodenal ulceration / metastatic carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/18/83 to 12/4/83, that (I) (we) last saw the deceased alive on 12/4/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE J. D. Spaulding, M.D. ST. AGNES Hosp. + 1		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BUR 881		23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY	
23d. LOCATION CITY OR TOWN BALTO		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME James A. Morton & Sons		ADDRESS 1701 LAURENS		25. DATE REC'D. BY REGISTRAR DEC 6 1983	
				26. REGISTRAR'S SIGNATURE John J. Lohr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>George F. Hudson, Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 15, 1983</i>			2b. HOUR M <i></i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 5, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balto. Gen. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Self employed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i></i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John</i> <i></i> <i>Hudson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cecelia</i> <i></i> <i>Conner</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>U.U. 2 215-03-6051</i>		17. INFORMANT ADDRESS <i>Mrs. Mary A. Hudson, Same as above</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardio-vascular collapse*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*minutes*

5715
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(b)*Advanced Liver Cirrhosis - toxic-plumbe - Hxv**months*DUE TO, OR AS A CONSEQUENCE OF
(c)*Renal-Hepatic failure**months**Ascrob with congestive failure**years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

*Incuria**condition after stroke**years*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 11</i> , 19 <i>1958</i> , to <i>Dec 15</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Dec 14/83</i> , 19 <i></i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Henry Armanas MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Dec 16/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HENRY ARMANAS, MD</i>				22e. ADDRESS <i>1934 Wilkens Ave. - Baltimore, Md 21223</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 19, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	



LIBRARY



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George T HUDSON			2a. DATE OF DEATH MONTH DAY YEAR 12-30-83			2b. HOUR 9:50 pm				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 29 30		6. AGE (IN YEARS LAST BIRTHDAY) 53		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 211 Bridgeview Rd 21225	
14. FATHER'S NAME FIRST MIDDLE LAST George Hudson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Hill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 247 46 3461		17. INFORMANT ADDRESS Annie A. Hudson 211 Bridgeview Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/30 , 19 83 , to 12/30 , 19 83 , that (I) (we) last saw the deceased alive on 12/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE YOUNG ON			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/31/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YOUNG ON			22e. ADDRESS F.H.N.C							
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 1/6/84		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, MD.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, this was self injury, or other traumatic event, the medical examiner must be notified.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN A COPY OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 2 1	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William L. Hughes										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12/4/83	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 9 25		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 12/4/83 19	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY M.T.A.	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1033 Regina Drive 21227	
14. FATHER'S NAME FIRST MIDDLE LAST George Hughes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Chlad					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 219-16-9229		17. INFORMANT ADDRESS Adele E. Hughes 1033 Regina Drive 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12/5/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/7/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR DEC 7 - 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

No.		Date		Locality		Collector		Notes	
1	1000	1910	10	10	10	10	10	10	10
2	1001	1910	10	10	10	10	10	10	10
3	1002	1910	10	10	10	10	10	10	10
4	1003	1910	10	10	10	10	10	10	10
5	1004	1910	10	10	10	10	10	10	10
6	1005	1910	10	10	10	10	10	10	10
7	1006	1910	10	10	10	10	10	10	10
8	1007	1910	10	10	10	10	10	10	10
9	1008	1910	10	10	10	10	10	10	10
10	1009	1910	10	10	10	10	10	10	10
11	1010	1910	10	10	10	10	10	10	10
12	1011	1910	10	10	10	10	10	10	10
13	1012	1910	10	10	10	10	10	10	10
14	1013	1910	10	10	10	10	10	10	10
15	1014	1910	10	10	10	10	10	10	10
16	1015	1910	10	10	10	10	10	10	10
17	1016	1910	10	10	10	10	10	10	10
18	1017	1910	10	10	10	10	10	10	10
19	1018	1910	10	10	10	10	10	10	10
20	1019	1910	10	10	10	10	10	10	10
21	1020	1910	10	10	10	10	10	10	10
22	1021	1910	10	10	10	10	10	10	10
23	1022	1910	10	10	10	10	10	10	10
24	1023	1910	10	10	10	10	10	10	10
25	1024	1910	10	10	10	10	10	10	10
26	1025	1910	10	10	10	10	10	10	10
27	1026	1910	10	10	10	10	10	10	10
28	1027	1910	10	10	10	10	10	10	10
29	1028	1910	10	10	10	10	10	10	10
30	1029	1910	10	10	10	10	10	10	10
31	1030	1910	10	10	10	10	10	10	10
32	1031	1910	10	10	10	10	10	10	10
33	1032	1910	10	10	10	10	10	10	10
34	1033	1910	10	10	10	10	10	10	10
35	1034	1910	10	10	10	10	10	10	10
36	1035	1910	10	10	10	10	10	10	10
37	1036	1910	10	10	10	10	10	10	10
38	1037	1910	10	10	10	10	10	10	10
39	1038	1910	10	10	10	10	10	10	10
40	1039	1910	10	10	10	10	10	10	10
41	1040	1910	10	10	10	10	10	10	10
42	1041	1910	10	10	10	10	10	10	10
43	1042	1910	10	10	10	10	10	10	10
44	1043	1910	10	10	10	10	10	10	10
45	1044	1910	10	10	10	10	10	10	10
46	1045	1910	10	10	10	10	10	10	10
47	1046	1910	10	10	10	10	10	10	10
48	1047	1910	10	10	10	10	10	10	10
49	1048	1910	10	10	10	10	10	10	10
50	1049	1910	10	10	10	10	10	10	10
51	1050	1910	10	10	10	10	10	10	10
52	1051	1910	10	10	10	10	10	10	10
53	1052	1910	10	10	10	10	10	10	10
54	1053	1910	10	10	10	10	10	10	10
55	1054	1910	10	10	10	10	10	10	10
56	1055	1910	10	10	10	10	10	10	10
57	1056	1910	10	10	10	10	10	10	10
58	1057	1910	10	10	10	10	10	10	10
59	1058	1910	10	10	10	10	10	10	10
60	1059	1910	10	10	10	10	10	10	10
61	1060	1910	10	10	10	10	10	10	10
62	1061	1910	10	10	10	10	10	10	10
63	1062	1910	10	10	10	10	10	10	10
64	1063	1910	10	10	10	10	10	10	10
65	1064	1910	10	10	10	10	10	10	10
66	1065	1910	10	10	10	10	10	10	10
67	1066	1910	10	10	10	10	10	10	10
68	1067	1910	10	10	10	10	10	10	10
69	1068	1910	10	10	10	10	10	10	10
70	1069	1910	10	10	10	10	10	10	10
71	1070	1910	10	10	10	10	10	10	10
72	1071	1910	10	10	10	10	10	10	10
73	1072	1910	10	10	10	10	10	10	10
74	1073	1910	10	10	10	10	10	10	10
75	1074	1910	10	10	10	10	10	10	10
76	1075	1910	10	10	10	10	10	10	10
77	1076	1910	10	10	10	10	10	10	10
78	1077	1910	10	10	10	10	10	10	10
79	1078	1910	10	10	10	10	10	10	10
80	1079	1910	10	10	10	10	10	10	10
81	1080	1910	10	10	10	10	10	10	10
82	1081	1910	10	10	10	10	10	10	10
83	1082	1910	10	10	10	10	10	10	10
84	1083	1910	10	10	10	10	10	10	10
85	1084	1910	10	10	10	10	10	10	10
86	1085	1910	10	10	10	10	10	10	10
87	1086	1910	10	10	10	10	10	10	10
88	1087	1910	10	10	10	10	10	10	10
89	1088	1910	10	10	10	10	10	10	10
90	1089	1910	10	10	10	10	10	10	10
91	1090	1910	10	10	10	10	10	10	10
92	1091	1910	10	10	10	10	10	10	10
93	1092	1910	10	10	10	10	10	10	10
94	1093	1910	10	10	10	10	10	10	10
95	1094	1910	10	10	10	10	10	10	10
96	1095	1910	10	10	10	10	10	10	10
97	1096	1910	10	10	10	10	10	10	10
98	1097	1910	10	10	10	10	10	10	10
99	1098	1910	10	10	10	10	10	10	10
100	1099	1910	10	10	10	10	10	10	10

PLANT INDUSTRY

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR AKA LANDFORD				2a. DATE OF DEATH MONTH DAY YEAR HOUR 12 9 83 3:20A			
1. DECEASED NAME FIRST MIDDLE LAST EDITH E HUNTER		3. SEX Female		4. RACE Col.		5. DATE OF BIRTH MONTH DAY YEAR 4-19-1944	
7a. BIRTHPLACE Balt. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 39 YRS		8. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Freddie Lee Hunter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agrada Lefosse Thomas		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-44-1093	
17. CAUSE OF DEATH (Enter only one cause per line for item 18, and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF SEPSIS (b) DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA (c)		18. CAUSE OF DEATH (Enter only one cause per line for item 18, and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF SEPSIS (b) DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA (c)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from 12/8 , 19 83 , to 12/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. O. H. OBATA, MD DEGREE MD				22c. ADDRESS 2609 LIBERTY HIGH		22d. DATE SIGNED 12/9/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-15-83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24. FUNERAL DIRECTOR NAME Joseph L. Russ				24b. ADDRESS 2222 W. North Ave		25. DATE REC'D BY REGISTRAR 31 REGISTRAR'S SIGNATURE DEC 13 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST JENNIFER L HUNTSBERRY				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5, 1983		2b. HOUR 6:10 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 5 1974		6. AGE (IN YEARS LAST BIRTHDAY) 9 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE PA		13b. COUNTY York		13c. CITY OR TOWN Thomasville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gary D Huntsberry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karan Sams		13e. STREET ADDRESS RD # 2 Box 865 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Gary D. Huntsberry Thomasville RD # 2, PA 17364			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOCIRCULATORY COLLAPSE 4860 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 7 DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (I) (this hospital) attended the deceased from 3 DECEMBER 1983 to 5 DECEMBER 1983 , that (I) (we) last saw the deceased alive on 5 DECEMBER 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L R PASTERNAK, MD				DEGREE MD		22c. DATE SIGNED 5 DEC 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L R PASTERNAK, MD				22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-7-1983		23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester PA	
24. FUNERAL DIRECTOR NAME John H. Harkins				ADDRESS 600 Main St, Delta, PA		25a. DATE REC'D. BY REGISTRAR DEC 09 1983	
				REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>HUTCHERSON, JULIA</i>					2b. HOUR <i>3:45 PM</i>	
3 SEX <i>F</i>		4 RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 15 04</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>78</i> YRS		
10 CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CUTHERAN HOSP</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.		
13a. STATE <i>MD</i>		13b. COUNTY <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Sam Square</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hester Square</i>		13e. STREET ADDRESS <i>1213 Light St 21230</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>226-12-9570</i>		17 INFORMANT ADDRESS <i>Doroth Potter 1012 W. Lombard St. 21223</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma colon with mets, sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1539</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypoglycemia, anemia</i>						
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— — — 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>— — — — —</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/11/83</i> 19 <i>—</i> to <i>12/11/83</i> 19 <i>—</i> that (I) (we) last saw the deceased alive on <i>12/11/83</i> 19 <i>—</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>—</i>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PARASHER</i>		22e. ADDRESS <i>House Officer - Lutheran Hosp</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-16-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>		
24 FUNERAL DIRECTOR NAME <i>Chas. A. Rice</i>		24b. ADDRESS <i>ESPA 1300 Eutaw Place</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. MD.</i>		
25. DATE REC'D. BY REGISTRAR <i>DEC 16 1983</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

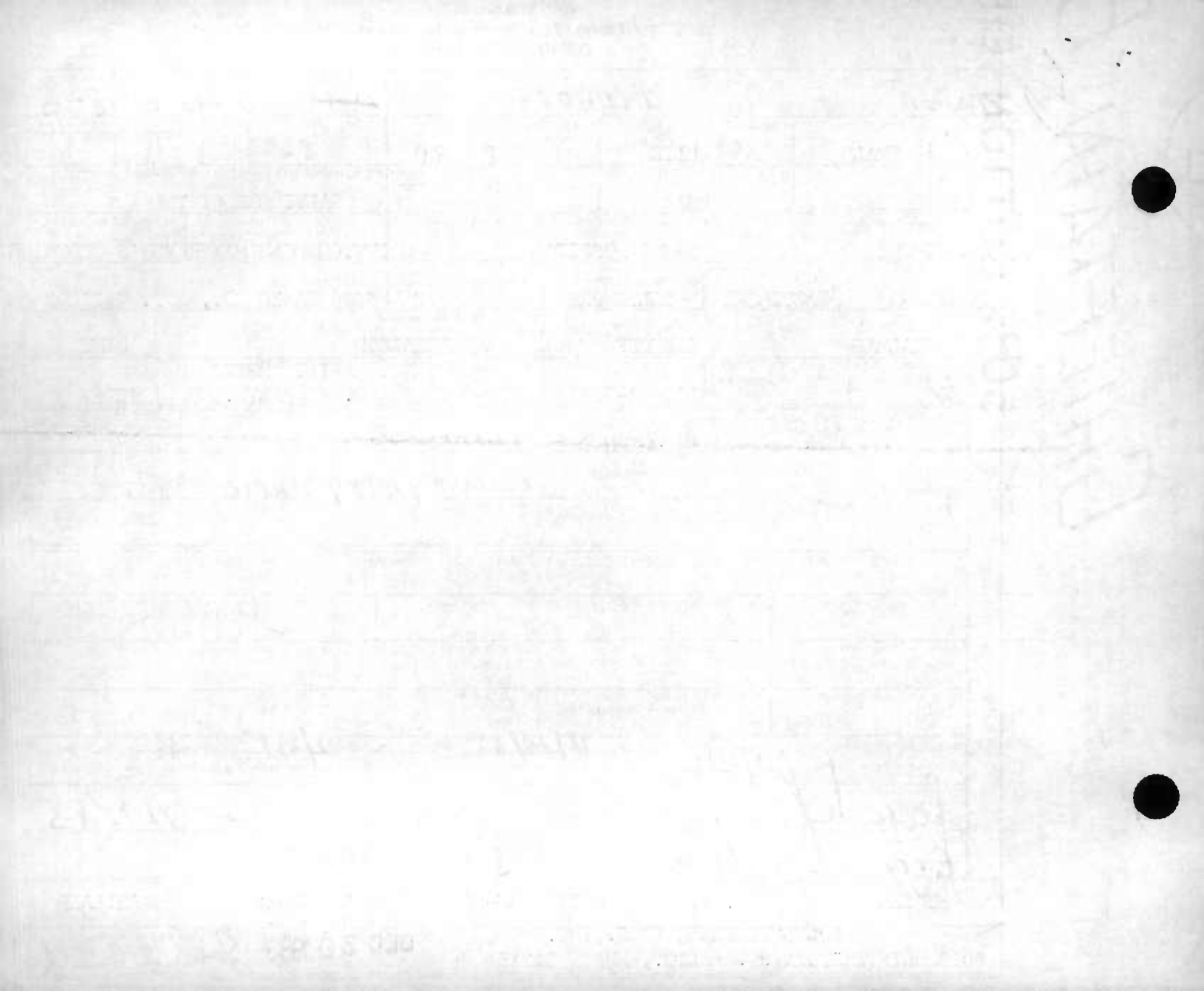
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANNA ISEKOFF			2a. DATE OF DEATH MONTH DAY YEAR 11 23 83			2b. HOUR 8:30 P.M.			
1. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 8 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUTTON HOLE MAKER		12b. KIND OF BUSINESS OR INDUSTRY MEN'S CLOTHING	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST KALMAN ISEKOFF				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH PINT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-01-5962		17. INFORMANT MRS. MARILYN MAINS		ADDRESS 6528-C SANZO RD. BALTO., MD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/20/83 , 19 83 , to 12/23/83 , 19 83 , that (I) (we) lost saw the deceased alive on 12/23/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Georgina Gilliam						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12.23.83	
22d. PHYSICIAN'S NAME (IF PRINT) Georgina Gilliam						22e. ADDRESS Sinai Hospital.			
23a. BURIAL INFORMATION, REMOVAL BURIAL			23b. DATE DEC. 26, 1983		23c. NAME OF CEMETERY OR CREMATORY CHITZUK AMUNO		23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE RECD. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediate reporting must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CALVIN JACKSON			2a. DATE OF DEATH MONTH 12 DAY 30 YEAR 83			2b. HOUR 4 AM	
3 SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 9 DAY 4 YEAR 1905		6 AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Circle Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labourer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Eddie		15. MOTHER'S MAIDEN NAME Amelia		16. STREET ADDRESS 1213 E. Eutaw Pl		17. INFORMANT Jacqueline Cox	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		18b. SOCIAL SECURITY NO. 519-10-1514		18c. ADDRESS 1213 Eutaw Pl			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Prostate. 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-5-82 , 19 82 , to 12-7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE G. Shah DEGREE MD		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. SHAH		22e. ADDRESS Key Circle Nursing Home - BALTIMORE					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-84		23c. NAME OF CEMETERY OR CREMATORY MT Zion Cem		23d. LOCATION CITY OR TOWN COUNTY STATE LAWSONVILLE A.A. MD	
24. FUNERAL DIRECTOR NAME Charles A. Rice FSPA ADDRESS 1300 Eutaw Pl				25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Gough	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Florence Jackson			2a. DATE OF DEATH MONTH DAY YEAR 12/12/83			2b. HOUR 12 05 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 13 02		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rock Hall, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Murray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 214 204975			17. INFORMANT Dr. Melvin L. Jackson			ADDRESS 1015 Edmondson Ave. Balto., Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiorespiratory Standstill**
DUE TO, OR AS A CONSEQUENCE OF
(b) **Multiple Myeloma**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 12/12/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiorespiratory Standstill		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 83 , to 12/12 , 19 83 , that (I) (we) last saw the deceased alive on 12/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. W. MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Ohlenger		22e. ADDRESS Univ. Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	

24. FUNERAL DIRECTOR
NAME **NUTTER & SONS** ADDRESS **2501 Gwynns Falls**
FUNERAL HOME INC. Pkwy. Baltimore, Md. 21216

25. DATE REC'D. BY REGISTRAR **DEC 15 1983**
26. REGISTRAR'S SIGNATURE
John J. Lohmeyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LOUISE E. JACKSON			2a. DATE OF DEATH MONTH DAY YEAR 12 15 83			2b. HOUR 7:28 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 27 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cooks		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry M. Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattlie Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 216-24-0928		17. INFORMANT ADDRESS Thomas Wheatley 5012 Palmer Ave.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

4130

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **UNSTABLE ANGINA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 min

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/6, 1983 to 12/15, 1983 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Salvaterra MD				DEGREE		22c. DATE SIGNED 12/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALVATERRA				22e. ADDRESS UNIV OF MD. HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, B.C. Md.	
24. FUNERAL DIRECTOR NAME Chas. A. Rice Funeral Ser				25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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E. J. JACKSON

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CARDINAL ARREST

UNUSABLE AREA

SAVATERRA

UNIVERSITY OF MARYLAND

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARVIN E. JACKSON			2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 83			2b. HOUR 259 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 5 DAY 02 YEAR 37		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BONSECOURS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE	
13a. STATE MD		13b. COUNTY BALTO		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2233 W FAYETTE ST 21223	
14. FATHER'S NAME FIRST James MIDDLE E. LAST Jackson				15. MOTHER'S MAIDEN NAME FIRST Fannie MIDDLE J. LAST Elias			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-36-8391		17. INFORMANT ADDRESS Karen Jackson 1517 N. Ellwood Ave			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

H. C. V. D., CHF.

DUE TO, OR AS A CONSEQUENCE OF

ALCOHOLISMPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

19a. DATE OF OPERATION 4029		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1773		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that this hospital attended the deceased from 12/12 to 12/13 , 19 83 , that I saw the deceased alive on 12/12 , 19 83 , and that in my opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)							
22b. SIGNATURE Howard B. Cohen M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD B. COHEN				22e. ADDRESS BONSECOURS HOSP.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Cotton" and "seed" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLIFFORD C. JAMES			2a. DATE OF DEATH MONTH DAY YEAR 12 6 83			2b. HOUR 4:05 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dean Emeritus		12b. KIND OF BUSINESS OR INDUSTRY Univ.-Balto.	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3811 Canterbury Rd. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST George T. James				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora ✓?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 092-03-5463		17. INFORMANT ADDRESS Elsie Kershaw Burlington, Ont.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, CAD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Uremia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-5 , 19 83 , to 12-6 , 19 83 , that (I) (we) last saw the deceased alive on 12-6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lannette C. Linthicum M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LANNETTE C. LINTHICUM, M.D.						22e. ADDRESS THE UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.						25a. DATE REC'D. BY REGISTRAR DEC 8 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1111 O. 1111



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILTON D JAMES -JAMES D -MILTON-		2a. DATE OF DEATH MONTH DAY YEAR 12/12/83		2b. HOUR 2:38P M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 26, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY High School
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alonzo James		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Duke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Mrs. Irene J. Hardy Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute antero-septal myocardial</u> <u>4100</u> <u>Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-10</u> , 19 <u>83</u> , to <u>12-12</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>OK DONG KIM</u>		DEGREE		22c. DATE SIGNED <u>12-12-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>OK DONG KIM</u>		22e. ADDRESS <u>St. Agnes Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 15 1983	
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES JAMES JAMISON			2a. DATE OF DEATH MONTH 12 DAY 23 YEAR 83			2b. HOUR 9:44P <small>AM</small>				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 10 DAY 22 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS <small>IF UNDER 24 HRS.</small> DAYS <small>HOURS</small> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY <small>MD.</small>				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6701 Laurel Drive 21207	
14. FATHER'S NAME FIRST Charles MIDDLE H. LAST Jamison				15. MOTHER'S MAIDEN NAME FIRST Hallie MIDDLE Turner LAST Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 213 12 3331		17. INFORMANT ADDRESS Marguerite F. Jamison 6701 Laurel Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) <u>massive intracerebral bleeding</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>metastatic prostatic cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>prostatic carcinoma @ renal vein.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 22 83 to DECEMBER 23 83 , that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> saw the deceased alive on DECEMBER 23 19 83 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) saw the body after death.										
22b. SIGNATURE Robie Suh MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robie Suh MD					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA			23d. LOCATION CITY OR TOWN Owings Mills COUNTY Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. ADDRESS 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 27 1983			25b. REGISTRAR'S SIGNATURE John J. Carver		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy Jamieson		December 29, 1983		12:50A	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8 25 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST INDIES	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS MYRIE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNELLA BARRETT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 218-09-6090		17. INFORMANT ADDRESS LOIS HARVEY 4009 DUVALL AVENUE 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure, Uremia 4039 DUE TO OR AS A CONSEQUENCE OF (b) Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO OR AS A CONSEQUENCE OF (c) Hypertension, Cardiac Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypothyroidism					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from December 20, 1983, to December 29, 1983, that (we) lost saw the deceased alive on December 29, 1983, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Patricia Weber MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAT WEBER MD		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS E.L. PHILLIPS 1721 N. MONROE ST.			
25a. DATE RECEIVED BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE John S. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is medical examiner matter and should be filed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR Item 21e&22a film 587 STATE REGISTRAR 1-30-84 cn					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) VITA L. JANCARAS					2a. DATE OF DEATH MONTH 12 DAY 7 YEAR 83			2b. HOUR 3:42 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 45		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer		12b. KIND OF BUSINESS OR INDUSTRY Groth.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Westerly		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1904 Cedar Circle Dr. 21228	
14. FATHER'S NAME FIRST Chester MIDDLE V. LAST Noreika					15. MOTHER'S MAIDEN NAME FIRST Marija MIDDLE Krecmeraite LAST Krecmeraite				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-78-5553		17. INFORMANT Raymond Jancaras		ADDRESS 21228 1904 Cedar Circle Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 9500 DUE TO, OR AS A CONSEQUENCE OF (b) severe Hypotension. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) severe Aspirin overdose									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) metabolic acidosis & Respiratory Alkalosis.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE SHOWRA O.S.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-7-83.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHOWRA O.S.					22e. ADDRESS St Agnes Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. ADDRESS 21229 4107 Wilkens Ave.					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 9 1983 John J. Canine				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

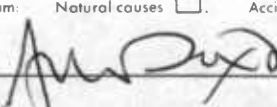

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(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST JAN			MIDDLE Marie			LAST JAY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 29 1983			2b. HOUR M 9:27 P	
3. SEX female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 17 1953		6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 1 1 1984			2d. HOUR M 9:27 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 831 Seagull Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21225 831 Seagull Avenue						
14. FATHER'S NAME FIRST MIDDLE LAST James E. Jay						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sheppard										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-62-9348		17. INFORMANT ADDRESS Apt 2 c Jo Ann Spruill 109 Caraway Rd										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Incised wound of neck</u> <u>9660</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> FOR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-29- 19 83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was stabbed.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 831 Seagull Ave., Balto. MD.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-2-84								
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/9/84		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown MD						
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave										25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE 				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 2B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thelma Jenkins			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1983			2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 11 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21217 727 Druid Park Lake Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST John Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Locken					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-14-8448		17. INFORMANT ADDRESS Carolyn J. Wright 1924 N. Chester St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>MANY YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (a) WORK (b) AT WORK <u>CLINIC</u>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-19-</u> 19 <u>83</u> , to <u>11-2-</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-31-</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Shaukat Y. Khan</u>					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-5-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAUKAT Y. KHAN					22e. ADDRESS 1528 KING WILLIAM DRIVE, Balt, MD 21228				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/5/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E, North Ave,					25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Lauer</u>		

CHILTERN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.											
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) MOSES SINCLAIR JENNINGS				2a. DATE OF DEATH MONTH 12 DAY 3 YEAR 83				2b. HOUR 1 P M			
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH 10 DAY 25 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JANITOR		12b. KIND OF BUSINESS OR INDUSTRY LABOR							
13a. STATE MARYLAND		13b. COUNTY BALTIMORE CITY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1025 S. HANOVER STREET							
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST JENNINGS				15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE LAST BAKER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 212 095823		17. INFORMANT (WIFE) ADDRESS ELLA MAE JENNINGS FA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest - CARDIAC 3229 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) UTER RESPIRATORY TRACT BLEEDING - DUE TO, OR AS A CONSEQUENCE OF (c) MEGALINITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 3 hours 3 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1 Chronic Sinusitis															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 83 , to Dec 3 , 19 83 , that (I) (we) lost saw the deceased alive on Dec 2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Michael E. Klufas				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/3/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Klufas				22e. ADDRESS 3001 S. HANOVER STREET BALTIMORE, MD 21230											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Baltimore COUNTY MD STATE MD							
24. FUNERAL DIRECTOR NAME Brown-Thompson F.H. ADDRESS 1913 W. Bacto. ST.				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conner									

RECEIVED
JAN 10 1917
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



THE
MILLS

20% COTTON

WASH. STATE
A. J. BROWN
JAN 10 1917

WASH. STATE
JAN 10 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the kind and location of injury must be stated on page 4.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH S JEPPI			2a. DATE OF DEATH MONTH DAY YEAR DEC. 18 1983		2b. HOUR 9:45 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR APR. 16 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY		10. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. CITY OR TOWN BALTO		13c. STREET ADDRESS 1502 FOREST PARK AVE	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH JEPPI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNETTA CITRANG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-03-6801		17. INFORMANT ADDRESS JENNIE JEPPI 1502 FOREST PARK AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) cute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 years+					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (XXXXXX) attended the deceased from October 8 , 19 74 , to December 18 , 19 83 , that (I) (xxx) saw the deceased alive on October 31 , 19 83 , and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above, (I) (xxx) did not view the body after death.					
22b. SIGNATURE Wilmer K. Gallagher, Jr., M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 19 December 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) McGallagher, Jr.		22e. ADDRESS 3455 Wilkens Avenue - Baltimore, MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/21/83		23c. NAME OF CEMETERY OR CREMATORY LODGE PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD		24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME EDMONDSON AVE			
25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE Joan J. Conner			

BP



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JAN 31 1954



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DHMH - 17
(VR A15 ME (5))
20M 4/821- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH KNOWN ESTI- MATED		MONTH DAY YEAR		2d. HOUR			
BERNARD J. JEROMIN								12-?-83		19		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
MALE	CAUC	02-19-27		56 YRS.						12-22-83		10:15A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		USA				Baltimore City						MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		1015 Cathedral Street 3F		Ret											
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md						BALTO		YES		1015 Cathedral Street		21201			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
BENJAMIN JEROMIN				AMELIA GIELNER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
YES				WW II				212-22-5096				ANNA WODARSKI 5520 SAGRARD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) D. Assistant MEDICAL EXAMINER								DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION COUNTY			
CREMATION				12/30/1983				WEST VIEW				BALTO, Co. MD			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
KACZOROWSKI FUNERAL HOME				2525 Fleet St. BALTO MD 21224				DEC 29 1983				John J. Conner			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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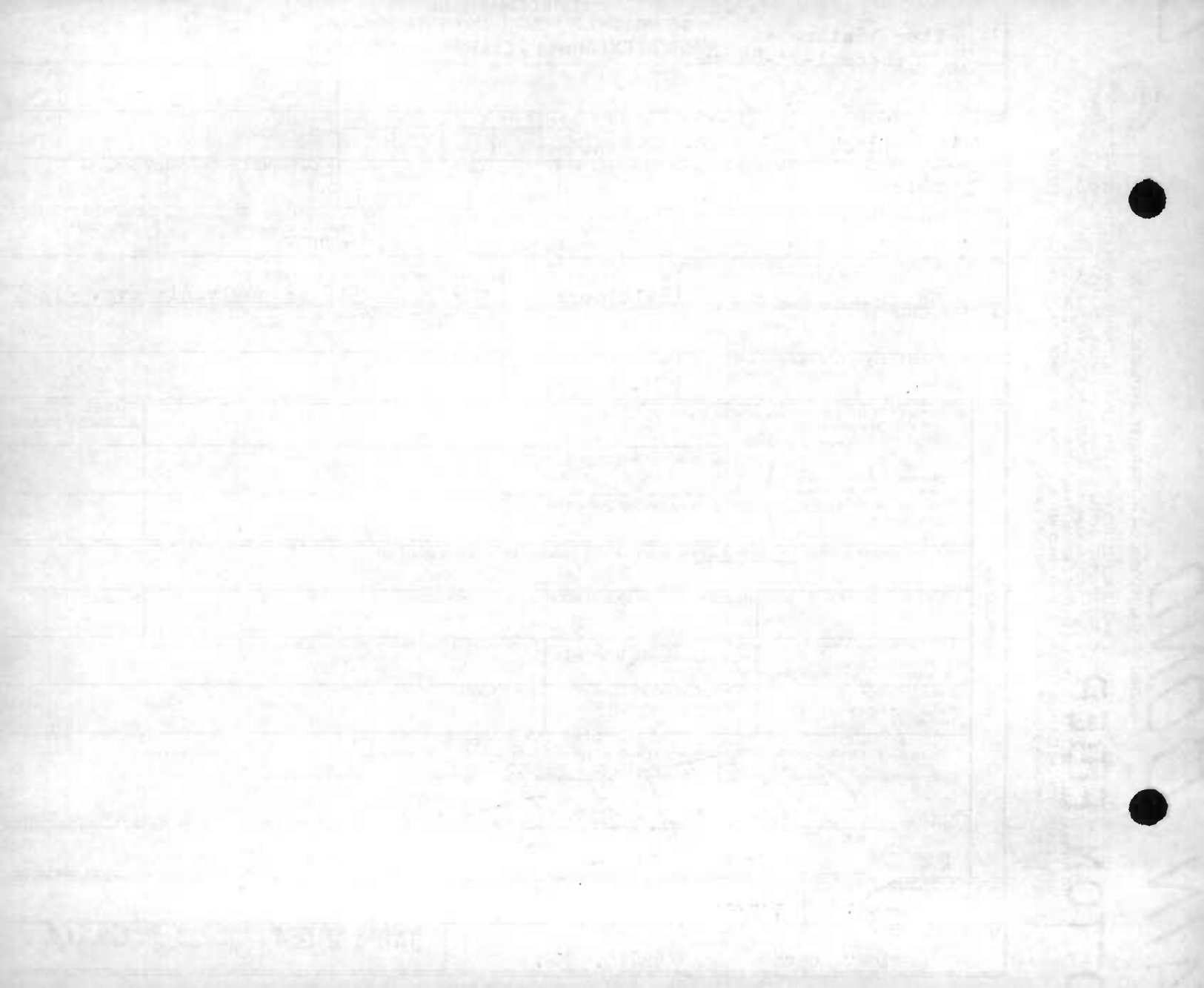
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
FOR STATE REGISTRAR Unkn. #83-90 Item 13athru e phone 1-23-84 ch										32540	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Daniel Johns						2a. DATE KNOWN OF DEATH 12 19 83		2b. HOUR M			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 28 35	6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 12 19 83		7d. HOUR 8:41P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2305 Etting Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2416 Pennsylvania ave. 21227			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. 213-30-0618		17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pancreatitis 5771 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12/20/83					
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.				ADDRESS		111 Penn St. Balto, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/5/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Smith			



Item 13e per ph.
12/29/83

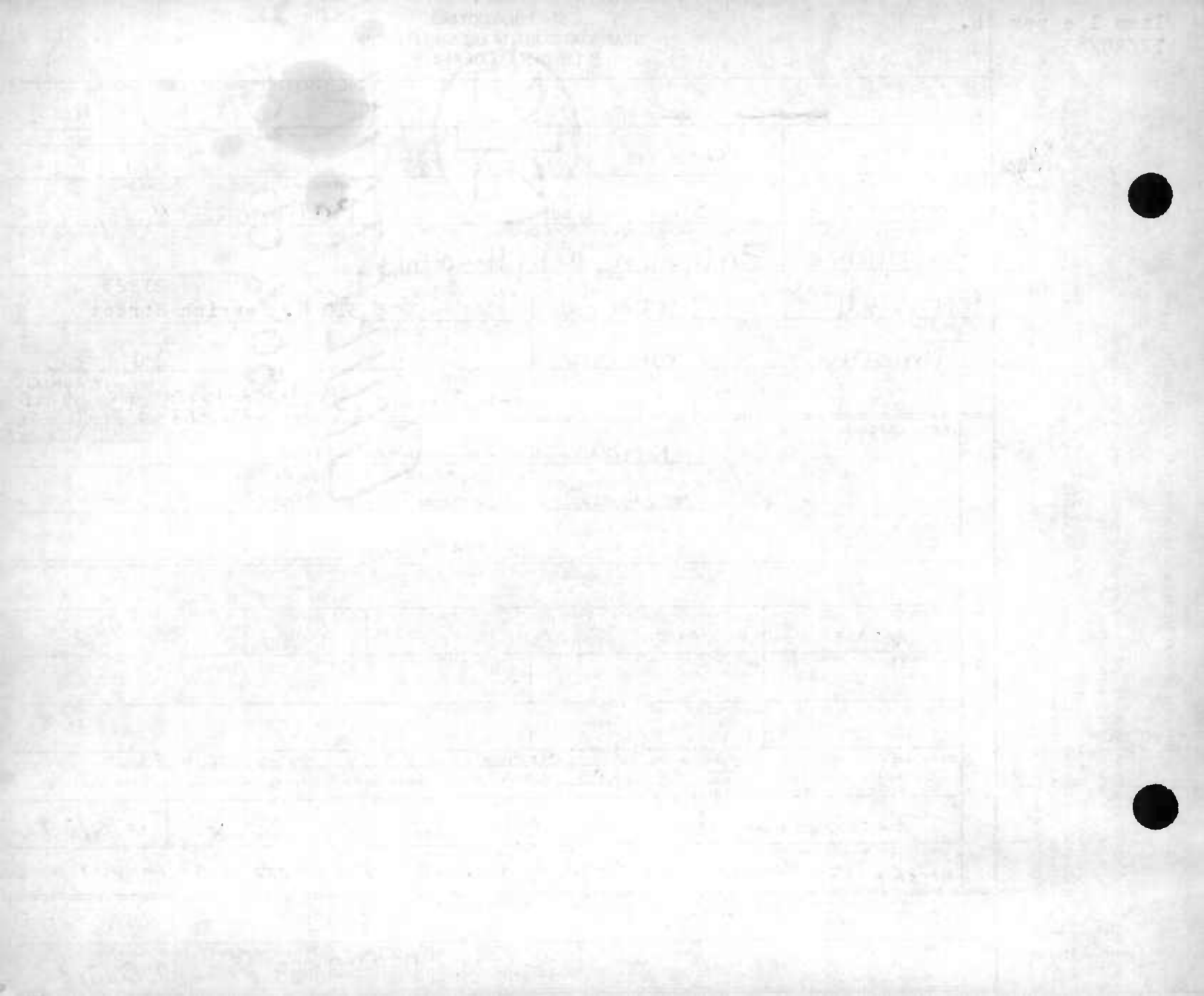
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or, item 18 allows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) REDACTED JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR 12 14 '83		2b. HOUR 11:20 AM				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 13 '83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 12 14		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21223 310 N. Perrish Street				
14. FATHER'S NAME FIRST MIDDLE LAST Timothy Blandings					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT Betty Johnson ADDRESS 310 N. PERRISH ST. # 3 GENERAL BALTIMORE 21223 MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERSISTENT FETAL CIRCULATION 7479 DUE TO, OR AS A CONSEQUENCE OF (b) MECONIUM ASPIRATION SYNDROME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASPHYXIA NEONATORUM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 13, 1983 to DECEMBER 14, 1983 , that (I) (we) lost saw the deceased alive on DEC. 14, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thelma Rosario Ames					DEGREE MD		22c. DATE SIGNED 12/14/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIA DEL ROSARIO F. AMES					22e. ADDRESS NURSERY, BALTIMORE CITY HOSPITALS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/20/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1983				
					25b. REGISTRAR'S SIGNATURE John J. Connel						

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR B. JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 12 30 83 9:00A.M.				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 08 19 07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Clerk		12b. KIND OF BUSINESS OR INDUSTRY Postal	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. BALTO					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4028 Boorman Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST STANSBURY Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 218-05-9990		17. INFORMANT ADDRESS Mrs. Hattie Seward - 3331 Alto Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5180 RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN (KNOWN TO HAVE L. Lung Atelectasis 20 to Lung Mass) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 MIN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/26, 19 83, to 12/30, 19 83, that (I) (we) lost saw the deceased alive on 12/30, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Douglas G. Martz Jr.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS G. MARTZ JR.				22e. ADDRESS SINAI HOSPITAL OF BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.			
24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS				ADDRESS 1701 LAURENS ST.		25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

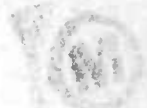
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Baby Girl Ashia Johnson				2a. DATE OF DEATH MONTH DAY YEAR 12/1/83			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 22 83		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. 0 MONTHS 9 DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Singi		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. CITY OR TOWN Balto		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Neal Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TRENA Zimmerman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Mr. Neal Johnson 3711 Dorchester Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7650 IMMEDIATE CAUSE (a) Multiple Complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoxia, Intraventricular Bleed, Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Prematurity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 25 week gestation							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1983, to 12/1, 1983, that (I) (we) lost saw the deceased alive on 12/1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard Scott Stahl				DEGREE MD		22c. DATE SIGNED 12/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R S Strahlman				22e. ADDRESS Singi Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-3-83		23c. NAME OF CEMETERY OR CREMATORY King Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.	
24. FUNERAL DIRECTOR NAME Mortons + Son				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. L... ..	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 4 4	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Earl Johnson										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/5/83	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR SEPT 24, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/5/83 19 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 Ashburton St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1000 Ashburton St 21216	
14. FATHER'S NAME FIRST MIDDLE LAST George Herbert Ross						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 21216 Mrs Dorothea Ross 1000 Ashburton St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease											
4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12/5/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 12-8-83		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CAM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph L. Ross 2222 W. NORTH AVE						25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Calish			

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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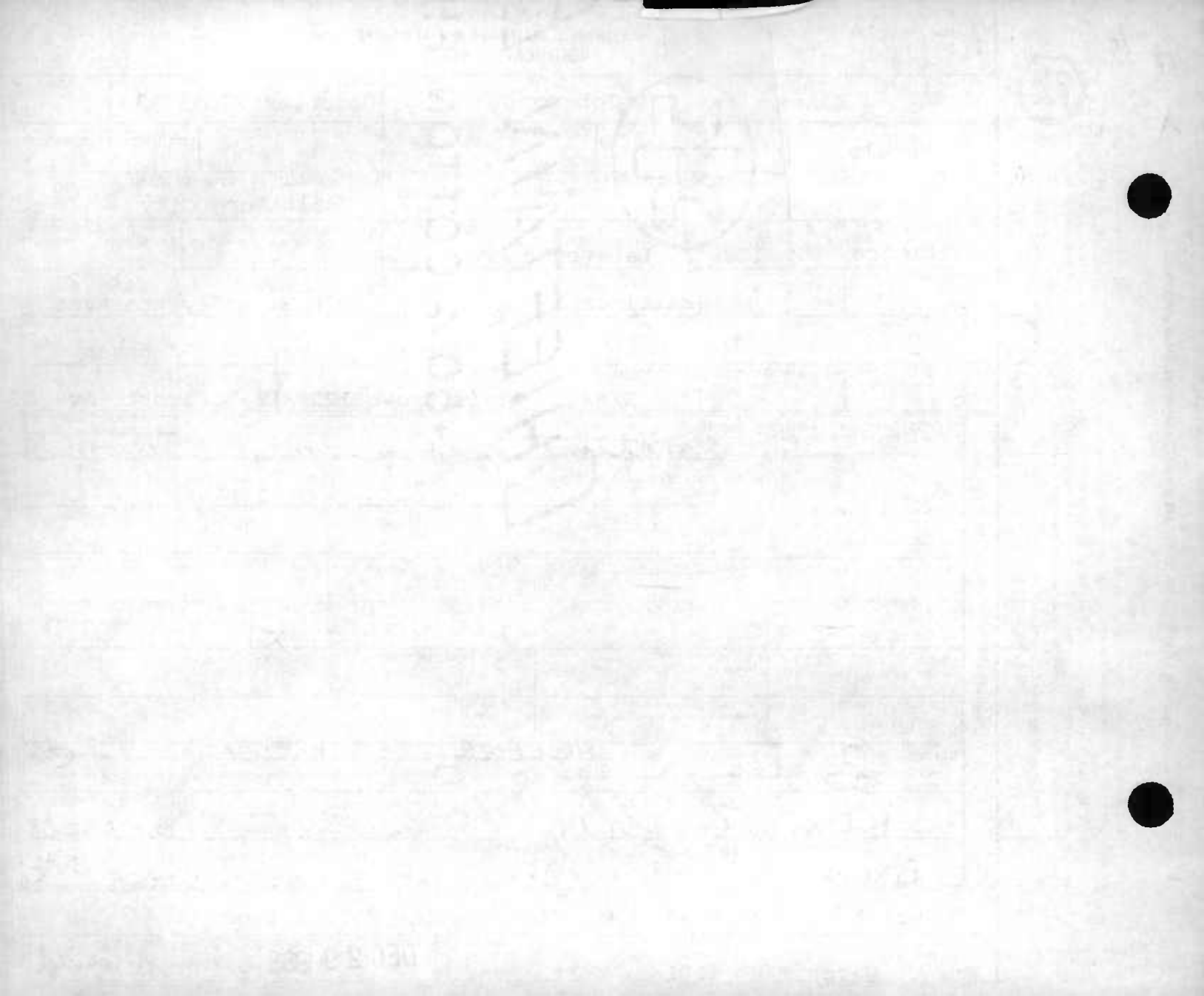
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edna Johnson			2a. DATE OF DEATH MONTH DAY YEAR December 27, 1983			2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1228 E. Lafayette Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1228 E. Lafayette Ave. 21202			
14. FATHER'S NAME FIRST MIDDLE LAST Georgia Mae Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Mae Johnson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. N/A			17. INFORMANT ADDRESS Alvis Brown 1228 E. Lafayette Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic lung cancer 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 83 to PRESENT 19 83 , that (I) (we) lost saw the deceased live on DEC 27 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Dolores M. Purnell MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 28 Dec 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dolores M. Purnell MD			22e. ADDRESS UNION MEMORIAL HOSPITAL HOSPICE, BALTO MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Carver		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hester E. JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR 12-18-83		2b. HOUR 12¹⁵ A				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-9-97		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE SQUARE NURSING CT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY Lochschilds			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8712 Eddington Rd. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas A. Hiser					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie J. Peacock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-03-2228		17. INFORMANT ADDRESS Sharon Glass 5714 The Alameda 21239							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Anotexia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/28 , 19 83 , to 12/18 , 19 85 , that (I) (we) last saw the deceased alive on 11/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Behreman					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 1) Burial		23b. DATE 12/21/83		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211					25a. DATE REC'D. BY REGISTRAR DEC 27 1983					25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEVI JOHNSON				2a. DATE OF DEATH MONTH DAY YEAR DEC. 20 1983			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 29 ?		6. AGE (IN YEARS LAST BIRTHDAY) 52?	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen. Hosp.		12a. USUAL OCCUPATION (Soc. Services)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS 554 Robert St. 21217			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-28-3202		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 1070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus ulcers and Urinary Tract Infection (c) Infection							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumothorax Right							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 24 , 19 83 , to DEC. 20 , 19 83 , that (I) (we) lost saw the deceased alive on DEC. 20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. VERGARA-SOARES				DEGREE M.D.		22c. DATE SIGNED 12-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. VERGARA-SOARES, M.D.				22e. ADDRESS N CHARLES GEN. HOSP. BALTO. MD. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.			

BP

JAN 03 1984 [Signature]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY F JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 12 22 83		2b. HOUR 10 ⁰¹ M
3 SEX F cm	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 05 30	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.		
10. CITY OR TOWN OF DEATH BALT. MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. DEMO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOOD SERVICE	12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN BALT.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LEONARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GARRIE DOBSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-28-4390	17. INFORMANT ADDRESS MR. DAVID FRAZIER 5931 RADECKE AVE. 21206		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3239 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) ENCEPHALITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on DEC 22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE J. J. Jones M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/22/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. J. Jones M.D.		22e. ADDRESS UNIV. HOSP.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/27/83	23c. NAME OF CEMETERY OR CREMATORY BUSHEY PARK CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE COOKSVILLE (HOWARD) MD.
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN		4517 PARK HEIGHTS AVENUE	25a. DATE REC'D. BY REGISTRAR DEC 27 1983
		25b. REGISTRAR'S SIGNATURE J. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 3 2 5 4 9	
FOR 1- STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PURNELL A JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1983	
3. SEX MALE					7b. HOUR 10:14 AM	
4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Aug 21 1966		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 52 W. West St. 21201		
14. FATHER'S NAME FIRST MIDDLE LAST Raymond S. Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Brightful		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 015-82-1587		17. INFORMANT Freda Johnson		ADDRESS 52 W. West St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST / HYPO TENSION 4254 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIO MYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) MYOCHARDITIS, VIRAL					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HYPO ADRENALISM, POSSIBLE SEPSIS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 83 , to 12/9 , 19 83 , that (I) (we) lost saw the deceased alive on 12/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rouven Roubenoff MD		DEGREE		22c. DATE SIGNED 12/9/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROUVEN ROUBENOFF MD		22e. ADDRESS JOHNS HOPKINS Hosp BALTIMORE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC. 15, 83		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN cem		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore		24. FUNERAL DIRECTOR NAME Brown-Thompson F.H.		25a. DATE REC'D. BY REGISTRAR DEC 13 1983		
25b. REGISTRAR'S SIGNATURE John A. Carver						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8332550					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Queenie A JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR 12 4 83				2b. HOUR 6:09 AM	
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 10 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 508 Bridgeview Road		
14. FATHER'S NAME FIRST MIDDLE LAST Louis (Lewis) FRAZIER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE (GRIFFIN) MATTHEWS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-5620		17. INFORMANT ADDRESS George E. Johnson 508 Bridgeview Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROBABLE ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY INSUFFICIENCY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 12 hours years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from December 3, 1983 , to December 4, 1983 , that (I) (we) last saw the deceased alive on December 4, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael E. Kluvas / Stern DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 12/4/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. KLUVAS / STERN				22e. ADDRESS 3001 S. Hanover Street Balto. Md. 21230						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/7/83		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley				

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



20% COLLOIDAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83

32551

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL H JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 12-29-83		2b. HOUR p.m. 8:30		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-18-10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr. - Carrier		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Fulton		13e. STREET ADDRESS 1133 Wilson Ave.		21207	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-4979		17. INFORMANT ADDRESS Mrs. Mamie Johnson (Same as #13.)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cancer of Prostate with metastatic Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-26, 1983, to 12-29, 1983, that (I) (we) lost saw the deceased alive on 12-29, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE Dr. Kanani		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KANANI		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST THOMAS			MIDDLE			LAST JOHNSON			2a. DATE KNOWN OF DEATH			ESTIMATED <input checked="" type="checkbox"/> 12 5 1983			2b. HOUR M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 26 18		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 12 7 1983			2d. HOUR M 2:13					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1003 N. Gay St.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21205 1003 N. Gay St. Apt. 204										
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odessa Johnson														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 135-16-5333		17. INFORMANT ADDRESS Evangeline Purnell 739 Argonne Dr.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 12-8-83								
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/12/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA				23d. LOCATION CITY OR TOWN COUNTY STATE Owing Mills, Md.										
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.						ADDRESS 1101 E North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 9 1983				25b. REGISTRAR'S SIGNATURE 						

UNITED STATES DEPARTMENT OF THE ARMY

DMC

RECEIVED



IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(VR A 15 (4)) 9/74

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		YEAR		2b. HOUR	
Thomas						JOHNSON		12		29		83		11A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS	
Male		Black		3 17 06		77		YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12. KIND OF BUSINESS OR INDUSTRY		13. BALTIMORE CITY OR COUNTY OF DEATH		14. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		U.S.A.				Baltimore City		Standard Oil Co.		oil		Baltimore City		Baltimore City	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		13c. CITY OR TOWN		13d. STREET ADDRESS		13e. CITY OR TOWN	
Baltimore		GARIBOLDI NURSING HOME		md		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		824 Broadway Street		Baltimore		21205		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS		17b. ADDRESS		17c. ADDRESS	
Frank		Gunter		UNKNOWN		214-163809		Dereck M. Smith		3803 Cornish Blvd		Baltimore		212167	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I. DEATH WAS CAUSED BY:		20. IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF (b)		22. DUE TO, OR AS A CONSEQUENCE OF (c)		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292		Cerebral Aneurysm		Cerebral Aneurysm		Cerebral Aneurysm		Cerebral Aneurysm		10 yrs		10 yrs		10 yrs	
26. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		27. none		28. none		29. none		30. none		31. none		32. none		33. none	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				19					
22a. I certify that (I) (this hospital) attended the deceased from 12/23/82 to 12/29/82, that (I) (we) lost		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY		22h. STATE	
		Edward J. Hunt		12/29/83		EDWARD J. HUNT		2803 Cornish Blvd		Baltimore		Baltimore		MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. REGISTRAR'S SIGNATURE		23h. REGISTRAR'S SIGNATURE	
Burial		12/28/84		Mt Zion		Baltimore		12/28/84		J. J. Hunt		J. J. Hunt		J. J. Hunt	
24. FUNERAL DIRECTOR (NAME)		24a. ADDRESS		24b. CITY OR TOWN		24c. COUNTY		24d. STATE		24e. DATE REC'D. BY REGISTRAR		24f. REGISTRAR'S SIGNATURE		24g. REGISTRAR'S SIGNATURE	
J. J. Hunt		3207 W. North		Baltimore		Baltimore		MD		12/28/84		J. J. Hunt		J. J. Hunt	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 5 4	
1. DECEASED NAME (TYPE OR PRINT) Valerie Johnson						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/12/83		2b. HOUR 2:40		2c. DATE PRONOUNCED DEAD 12/12/83	
3. SEX F	4. RACE Negro	5. DATE OF BIRTH MONTH 12 DAY 18 YEAR 59	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD 12/12/83		2d. HOUR A		2e. DATE PRONOUNCED DEAD 12/12/83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE M.D.		13b. COUNTY —		13c. CITY OR TOWN BALTO.		13e. STREET ADDRESS 311 Demby Town Rd.					
14. FATHER'S NAME FIRST Matthews MIDDLE — LAST Johnson				15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE — LAST Shelton				16. SOCIAL SECURITY NO. 212-80-0844			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-80-0844				17. INFORMANT ADDRESS MRS. Dorothy Shelton 511 Demby Town Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) — (c) —										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 12/12/83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subj. passenger in auto/auto collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE I-95 and Caton Ave., Balto., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Dep. Chief				DATE SIGNED 12/12/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/17/83		23c. NAME OF CEMETERY OR CREMATORY Hsbury Methodist Church		23d. LOCATION CITY OR TOWN COUNTY STATE Wheaton Md.			
24. FUNERAL DIRECTOR NAME Betts Funeral Home				ADDRESS 129 N. Calopine St.				25a. DATE REC'D. BY REGISTRAR DEC 14 1983		25b. REGISTRAR'S SIGNATURE Joan J. Canine	

MEDICAL CERTIFICATION

THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA E. JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR 12 / 22 / 83			2b. HOUR 1:40 AM		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 / 06 / 38		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2306 Robb Street 21218	
14. FATHER'S NAME FIRST MIDDLE LAST William Jones					15. MOTHER'S MAIDEN NAME FIRST MIDDLE Bernice White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-34-4908		17. INFORMANT ADDRESS Bernice Sanders 2306 Robb Street						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS, PNEUMONIA 1749 DUE TO, OR AS A CONSEQUENCE OF (b) CA of the BREAST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12 / 15 / 83, to 12 / 22 / 83, that (I) (we) last saw the deceased alive on 12 / 22 / 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE L. C. CHERN				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. C. CHERN				22e. ADDRESS LUTHERAN HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Carver				

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NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Memorial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		12-7-83		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR 12-30-1906		76		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Balto.		1507 Northbourne Rd.-21239		Sun Paper Route		Carrier-Retired					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.				Balto.				YES		1507 Northbourne Rd.-21239	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Benjamin H. Johnson		Venetia P. Hobbs									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		219-01-4965		Mrs. Katherine J.E. Johnson		Rd. 21239 1507 Northbourne					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Carcinoma of Lung								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PARKINSONS Syndrome - end stage									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12-1-19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		10 73		12-7-83							
22b. SIGNATURE D. H. Johnson		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-10-83		Immanuel Lutheran Cem.		Balto. Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc.		-6415 Belair Rd.-21206		DEC 9 1983		John J. Carver					

BP

20% CO₂

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES EDWARD JOHNSTON			2a. DATE OF DEATH MONTH DAY YEAR 12 31 83			2b. HOUR 10:35p_M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 16 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MARYLAND 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergyman		12b. KIND OF BUSINESS OR INDUSTRY Religious	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 215 Old Magothy Bridge Rd. (21122)	
14. FATHER'S NAME FIRST MIDDLE LAST John Johnston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amella Houck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 075 16 9295		17. INFORMANT ADDRESS Linda Revere 7848 Twin Ridge Dr. (21061)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the colon 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George Llawes MD DEGREE						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE LLAWES M.D.						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.		
24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy.						25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 5 5 8	
1. DECEASED NAME (TYPE OR PRINT) Cora Jones						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 4 19 83		2b. HOUR 12:22			
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR MAY 5, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 4 1983		2d. HOUR 12:22			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE				13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4805 HOMER AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 12 3924		17. INFORMANT ADDRESS MRS. JOSEPHINE WAITES 76 ST. NICHOLAS PL. NEW YORK, N. Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wounds to chest 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR P.M. 12 3 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4805 Homer Ave. Balto. Md							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . and in my opinion											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12/4/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD.			
24. FUNERAL DIRECTOR NAME ADDRESS LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				25a. DATE RECD. BY REGISTRAR DEC 6 1983							



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1305 KENNY AVENUE
BALTIMORE
MD 21215

BALTIMORE

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JULY 12 1908

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12/10/83
BALTIMORE (MD)
BALTIMORE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Essie B. Jones			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1983			2b. HOUR 11:02AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 30 23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2006 Park Avenue 21217		
14. FATHER'S NAME FIRST MIDDLE LAST John Willis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 231-28-0295			17. INFORMANT Louise Thomas			17. ADDRESS Apt. 4D 1701 Madison Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1509 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Esophageal Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Right Middle & Lower Lobe Pneumonia; Dysphagia and Weight Loss; Heavy Alcohol and Tobacco Abuse									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13, 1983 , to December 18, 1983 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 18, 1983 , and that in my <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Latief M. Hamed, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Latief M. Hamed, M.D.						22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-212

December 18, 1983

Jones

Essex

Baltimore City

Maryland General Hospital

Religion

30 Minutes

Respiratory Arrest

Metastatic Esophageal Carcinoma

Right Middle & Lower Lobe Pneumonia: Esophagus and Weight Loss: Heavy Alcohol and Tobacco Abuse

XX

X

December 18, 83

83

December 13, 83
XX

December 13, 83

12/18/83

Latif M. Hamed, M.D.

c/o Maryland General Hospital



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES JONES			2a. DATE OF DEATH MONTH DAY YEAR 12 / 7 / 83			2b. HOUR 8 45 AM				
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 2 32		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J.L. DEATON MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21215 2835 W. Garrison Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Marion Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 245-42-9160		17. INFORMANT ADDRESS Jean Norris 2835 W. Garrison Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) 5 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 83 , to 12/7 , 19 83 , that (I) (we) last saw the deceased alive on 12/7 , 19 83 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Deborah Thompson MD			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/7/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah Thompson MD			22e. ADDRESS J.L. Deaton Medical Center							
23a. BURIAL, CREMATION, REMOVAL (b) BURIAL			23b. DATE 12/12/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. Arbutus,		23d. LOCATION CITY OR TOWN COUNTY STATE MD			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E. North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 8 1983		25b. REGISTRAR'S SIGNATURE John J. Carney			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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20% COTTON FIB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James A Jones				2b. DATE OF DEATH MONTH DAY YEAR HOUR 12 1 1983 8 52 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 21213 2042 N. Washington St. (13)	
14. FATHER'S NAME FIRST MIDDLE LAST James Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Pharthenia Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 216-07-1584		17. INFORMANT ADDRESS Doris Coleman 7916 Denton Dr. Clinton MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Gram negative bacterial sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Malnutrition, status post cerebral vascular accidents, venous stasis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mark Richards				DEGREE MD		22c. DATE SIGNED 12/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark E. Richards MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

4

112-115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
LELA C JONES		12-26-83	
3. SEX	4. RACE	5. DATE OF BIRTH	7b. HOUR
Female	Black	04 28 1919	2:35 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	6. AGE (IN YEARS LAST BIRTHDAY)	8. YRS.
North Carolina	U.S.	64	
9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore City	Baltimore	BONSECOURS HOSPITAL	Retired
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.
Charlie	Bessie		237-18-2193
17. INFORMANT	ADDRESS	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Helen Spencer	2153 Hollins St	PART I. DEATH WAS CAUSED BY:	
		IMMEDIATE CAUSE (a) <u>pneumonia, pneumonia</u>	
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral infarction</u>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral vascular insufficiency</u>	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>diabetes mellitus</u>	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	HOUR A.M. MONTH DAY YEAR		
	P.M. 19		
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>12-17</u> , 19 <u>83</u> , to <u>12-26</u> , 19 <u>83</u> , that (I) <u>did not</u> last saw the deceased alive on <u>12-24</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>MD</u>		<u>12-26-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<u>STEPHEN R. SMITH, MD</u>		<u>8709 HARFORD RD., BALTIMORE, MD. 21234</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
<u>BURIAL</u>	<u>12-31-83</u>	<u>MT. AUBURN CEM</u>	<u>BALTO. CITY</u>
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
<u>BROWN-TOMPSON PA.</u>		<u>DEC 27 1983</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
<u>John J. Givens</u>		<u>John J. Givens</u>	

[Faint handwritten notes and markings are visible across the page, including some numbers like "40" and "94".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Violetta W Jones						2a. DATE OF DEATH MONTH DAY YEAR 12 8 83		2b. HOUR 3:00 AM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 02 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 827 N. Arlington			
14. FATHER'S NAME FIRST MIDDLE LAST William Wright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Wright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-01-6403		17. INFORMANT ADDRESS Vernetta P. Lonesome 3306 Glen Ave 21215							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7855 IMMEDIATE CAUSE (a) cardiopulmonary collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 83 , to 12/8 , 19 83 , that (I) (we) lost saw the deceased alive on 12/7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lloyd Stahl						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd Stahl						22e. ADDRESS Lutheran Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-13-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Chas. A. Rice FSPA 1300 Eutaw Place						25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Canine			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME FIRST MIDDLE LAST <i>George Jordan</i>		MONTH DAY YEAR <i>10/18/83</i>		HOUR MIN. <i>2:55 AM</i>	
SEX <i>male</i>	4. RACE <i>black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8 11 27</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N. Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>city</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital of Baltimore</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Balt</i> 13c. COUNTY <i>Balt</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>5606 Hayward Ave 21215</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Loreno Jordan</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>NANNIE B. DREW</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>237 36 3724</i>	17. INFORMANT ADDRESS <i>M. NAWEL Jordan NANKKIN Vn</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia → Respiratory Insuff.</i> <i>3030</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Seizure disorder</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ETOH abuse</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1) Intracerebral hematoma 2) cerebral hypoxia → coma 3) abs 4) septic 5) apoplegically</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Risa Burns</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>10/18/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RISA BURNS MD</i>	22e. ADDRESS <i>Sinai Hosp. of Balt. Balt MD 21215</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Removal</i>	23b. DATE <i>12/20/83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MT Zion</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Seaboard MD</i>		
24. FUNERAL DIRECTOR NAME <i>MANUEL M. HAYES 638 W. Colman St</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HATTIE A JORDAN			2a. DATE OF DEATH MONTH DAY YEAR 12 18-83		2b. HOUR M
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 29 10		6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S. of A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY Maryland	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE Md.			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Bower			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Jordan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 228-20-8334		17. INFORMANT ADDRESS MRS. INEZ JOHNSON 84 MORELAND ST. ROXBURY, MASS.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

1629

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **SQUAMOUS CELL CARCINOMA OF LUNG**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

COPD

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. Shamsuddin				DEGREE MD	22c. DATE SIGNED 12/20/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SHAMSUDDIN				22e. ADDRESS ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/22/83	23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE PORTSMOUTH (NO CO.) VA.
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24. FUNERAL DIRECTOR NAME Leona T. Gwynn	25a. DATE REC'D. BY REGISTRAR DEC 20 1983	25b. REGISTRAR'S SIGNATURE John G. Criss
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, collection by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) FREDERICK W. Jung					2a. DATE OF DEATH MONTH DAY YEAR 12/24/83	
3. SEX Male					2b. HOUR 10:10 A.M.	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) 76		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Giftware				
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 15-C Cross Keys Rd. 21210		
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Jung		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Miester				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 092-24-3762		17. INFORMANT ADDRESS Edelgard Jung 15-C Cross Keys Rd. 21210		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from 11/24, 1983, to 12/24, 1983, that I saw the deceased alive on 12/24, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.						
22b. SIGNATURE John W. Bowie MD DEGREE				22c. DATE SIGNED 12/24/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 26, '83		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery Baltimore, Maryland		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR DEC 27 1983		23f. REGISTRAR'S SIGNATURE John L. Smith		
24. FUNERAL DIRECTOR NAME William E. Johnson		24b. ADDRESS 8521 Loch Raven Blvd.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or police officer must be notified.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EARLE Williamson JUSTI Justi			2a. DATE OF DEATH MONTH DAY YEAR 12-6-83			2b. HOUR 2:27P M				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8-14-1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Foreman		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Maryland			13b. CITY OR TOWN Balto. Co.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 5302 Brabant Road 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Louis Justi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Williamson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 705-10-2411		17. INFORMANT ADDRESS Evelyn M. Justi 5302 Brabant Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease one year CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 19 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1983 to Dec 6, 1983 , that (I) (we) last saw the deceased alive on Dec 6, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jeffrey F. Cole, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 12/6/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey F. Cole, M.D.						22e. ADDRESS 3455 W. Williams Ave. 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-7-83		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville (Balto.) Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Raymond C. Fink Glen Burnie, Md.						25. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

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1-4-3

RECEIVED

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR IDA KAHLER					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA Kahler					2a. DATE OF DEATH MONTH DAY YEAR 12 10 83			2b. HOUR P M 11:20 P	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 09 04 14		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8026 NEIGHBORS AVE. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST ----- HORKEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -----				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213012824		17. INFORMANT ADDRESS JOHN KAHLER 8026 NEIGHBORS AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative adult respiratory distress syndrome 19d DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Divertericular abscess DUE TO, OR AS A CONSEQUENCE OF (c) 19d APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19d									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION 11/21/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Divertericular abscess colon				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/15/83 19 to 12/10/83 19		22. I certify that (I) (this hospital) attended the deceased from 12/10 1983 saw the deceased alive on 12/10 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) did not view the body after death.			
22b. SIGNATURE Sheldon M. Glusman MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 14/11/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheldon M. Glusman MD		22e. ADDRESS The Good Samaritan Hosp., BALT, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.		25a. DATE REC'D. BY REGISTRAR DEC 13 1983	
24. FUNERAL DIRECTOR John J. Carver		ADDRESS 1211 CHESAPE AVE - BALTO MD		25b. REGISTRAR'S SIGNATURE John J. Carver					

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Keywords: *Therapist self-efficacy; Client self-efficacy; Self-efficacy; Therapeutic alliance; Client participation*

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John R. Kalista, Sr.			2a. DATE OF DEATH MONTH December DAY 24 YEAR 1983			2b. HOUR 11:30 AM	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 17 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Salesman	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STREET ADDRESS 4411 Ekenyer Rd.				21236			
14. FATHER'S NAME FIRST Michael MIDDLE John LAST Kalista				15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE Roberts LAST Roberts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-12-0439		17. INFORMANT ADDRESS Mrs Dorothy A Kalista Same As 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

2028

IMMEDIATE CAUSE (a)

Malignant Lymphoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from April , 19 83 , to December 24 , 19 83 , that (I) (we) lost saw the deceased alive on December 24 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Chang, M.D.				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED Dec. 24, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Chang, M.D.				22e. ADDRESS Good Samaritan Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and Registrar, it should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item 19b film 587 3-30-84 en									
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES T KANE Sr.					2a. DATE OF DEATH MONTH DAY YEAR 12. 9. 83		2b. HOUR 3:43 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 9-06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Bath Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired (none)		12b. KIND OF BUSINESS OR INDUSTRY Operator	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1523 E. Clement St. Balto. Md. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST James J. KANE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine KESSLER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 112-09-5887A		17. INFORMANT ADDRESS Carwyn Chambers, 319 W. 6th. Ave. Balto. Md. 21225							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 6000 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Bilateral stroke									
19a. DATE OF OPERATION 10/20/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign prostatic hypertrophy Transurethral Resection				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1983, to Nov. 5, 1983, that (I) (we) last saw the deceased alive on Nov. 19, 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE R K		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12. 9. 83 5:30 PM	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMESH K. KHURANA M.D.				22e. ADDRESS 606 U-6 HAMMONDS LANE BALTO 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Dec. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230				25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE James J. Carver			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
THELMA D. KANE				12 10 83		11P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
F	W.	5 23 12		71 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	USA			Baltimore, City MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	St. Agnes Hospital			HOMEMAKER		---	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Md.				Baltimore		2934 Stafford St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
WILLIAM KEIL				LENA SCHLUTTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO				215-03-2935		Francis Kane 2934 Stafford St. 21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 1629 RESPIRATORY ARREST							1 1/2 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA - SMALL CELL VARIETY							5 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 10 DEC 1983, to 10 DEC 1983, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 10 DEC 1983, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE Andrew Trofa				DEGREE MD		22c. DATE SIGNED 10 DEC 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Andrew Trofa				900 Caton Ave. Baltimore, MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		12-14-83		LOUDON PARK		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				21229 DEC 14 1983		John J. Lander	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 5 7 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) TONYA L KANE			2a. DATE OF DEATH MONTH DAY YEAR 12 21 83			2b. HOUR 10:20 A.M.			
3. SEX Fem		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 19 66		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MARCELLUS KANE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis SCURRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 218-78-8086				17. INFORMANT ADDRESS EMERGENCY REGISTRATION RECORD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Brain Death
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypoxia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

12/20/83 (1 day)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Adult Respiratory distress Syndrome / Sickle Crisis

19a. DATE OF OPERATION 12/15/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Failure of Progression of LADVD		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/13, 1983, to 12/21, 1983, that (I) (we) lost saw the deceased alive on 12/21/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David Schamp MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID SCHAMP MD				22e. ADDRESS 22 S. Greene ST Balto. MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD	
24. FUNERAL DIRECTOR NAME Brown-Thompson F.H.				ADDRESS 1913 W. Balto. ST.		25. DATE REC'D. BY REGISTRAR DEC 27 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Page 4, and 5, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNIVERSITY OF MARYLAND BALTIMORE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it indicates an examination must be made by a physician.

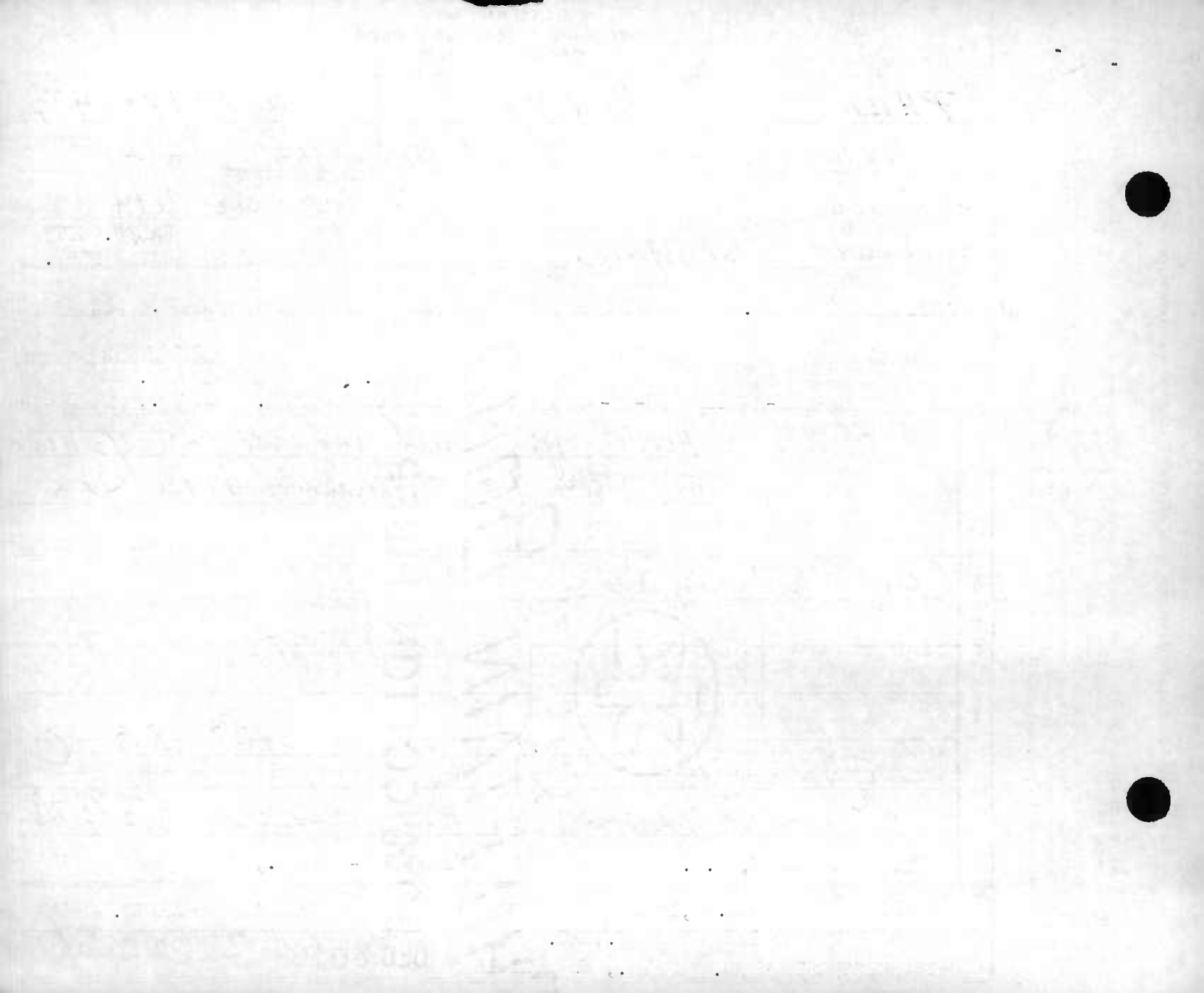
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PHILIP KANTOR		12/27/83		4:05 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 24 1910	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	7. IF UNDER 1 YEAR MONTHS DAYS 8 24	8. IF UNDER 24 HRS HOURS MIN 4 05
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	9b. CITIZEN OF WHAT COUNTRY? US	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levin Dale		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RATE SETTER		
13a. STATE MARYLAND		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LEON KANTOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WEINSTOCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII-ARMY 213-10-5596		17. INFORMANT ADDRESS MRS. BERTHA LEGUM APT. 2C 6992 MILBROOK PARK DR. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic cardiovascular disease yrs (c) CVA w/Chemparides PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 8/13/80 to 12/27/83 , that (1) (we) last saw the deceased alive on 12/27/83 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven Levenson		DEGREE MD		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN LEVENSON, M.D.		22e. ADDRESS LEVINDALE - BALTO., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 29, 1983		23c. NAME OF CEMETERY OR CREMATORY RUDOMER VEREIN	
23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD		24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			
25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M. KAPOVICH			2a. DATE OF DEATH MONTH DAY YEAR 12 3 83		2b. HOUR 1130 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 12 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Md. Port Adm.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. Baltimore Eastwood		13b. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13c. STREET ADDRESS 7006 Bank St. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST GOST KAPOVICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARK BRUZINSKA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) Yes W.W. 2		16b. SOCIAL SECURITY NO. 217 072561	
		17. INFORMANT ADDRESS Anna E. Kapovich 7006 Bank Street 21224					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1579 IMMEDIATE CAUSE (a) **cardiovascular failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **metastatic cancer of the pancreas**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 83 , to 12/3 , 19 83 , that (I) (we) lost saw the deceased alive on 12/3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Frederick MO PHYSICIAN'S NAME (TYPE OR PRINT) J. FREDERICK				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/3/1983	
22d. ADDRESS 8BSH.							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem;		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Charles S. Zeiler & Son Inc. 6224 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MICHAEL KAPPER			2a. DATE OF DEATH MONTH 12 DAY 03 YEAR 83			2b. HOUR 943 M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 06 DAY 25 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS HOURS 00 MIN. 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY DECORATOR		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN BALT. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS #21209 3016 FALL STAFF MANOR CT.											
14. FATHER'S NAME FIRST TOVI MIDDLE JACOB LAST KAPUSTAN				15. MOTHER'S MAIDEN NAME FIRST FANNIE MIDDLE ALEXANDER LAST ALEXANDER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 358-03-2962		17. INFORMANT MR. MURRAY KAPPER 9811 WINANDS RD. RANDALLSTOWN, MD 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11-30 , 19 83 , to 12-3 , 19 83 , that (1) (we) lost saw the deceased alive on 12-3 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. ORDOQUI				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-3-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ORDOQUI				22e. ADDRESS SINAI HOSPITAL, BALT. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC. 5, 1983		23c. NAME OF CEMETERY OR CREMATORY PROGRESSIVE BENEFIT & RELIEF ASSOC.		23d. LOCATION COUNTY BALTO. STATE MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OF THE FBI
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LAST FIRST MIDDLE Kazimierz				2a. DATE OF DEATH MONTH DAY YEAR 12 23 83			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 25 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL KARASINSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA ZELINSKA		13e. STREET ADDRESS 336 HORNEL ST.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 36 8922A		17. INFORMANT ADDRESS HELEN KARASINSKI 336 HORNEL ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Basilar Cerebrovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Accident.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension, TIA.							
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) no			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/22 , 19 83 , to 12/23 , 19 83 , that (I) (we) last saw the deceased alive on 12/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Greenberg MD				DEGREE MD		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Greenberg				22e. ADDRESS Balt. City Hospital			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12-27-1983		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR R.L. KACZOROWSKI				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELENE V. KASTNER			2a. DATE OF DEATH MONTH DAY YEAR 12 25 83				2b. HOUR 5A M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 14 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1205 Carroll Street 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Koehl				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhemina Giese					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-24-0451		17. INFORMANT ADDRESS Carolyn Miller 2043 Eagle Street 21223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRAINSTEM STROKE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SEVERE ATHEROSCLEROSIS</u>									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 19</u> 19 <u>83</u> to <u>DEC 25</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L.B. Cameron</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/25/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CAMERON</u>				22e. ADDRESS <u>University of MD Dept of Medicine</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk. Elkridge		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

5



CHIEF

CHIEF

100%

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John F. Kavanagh			2a. DATE OF DEATH MONTH DAY YEAR Dec. 21, 1983			2b. HOUR M				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE FACILITY NAME AND STREET ADDRESS) 913 N. Calvert St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. City Editor		12b. KIND OF BUSINESS OR INDUSTRY News-Post		
13a. STATE Md			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 913 N. Calvert St 21202	
14. FATHER'S NAME FIRST MIDDLE LAST Hugh I. Kavanagh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mc Carthy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-7090			17. INFORMANT ADDRESS Mrs. J. F. Kavanagh 913 N. Calvert St				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

LUNG Cancer

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 months

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/2, 1983, to 12/2, 1983, that (1) (we) lost saw the deceased alive on 12/2, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stuart B. Bell M.D.		22c. DATE SIGNED 12/23/83				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart B. Bell M.D.	
		22e. ADDRESS 3561 St. Paul St #140					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Mitchell--Wiedefeld Home 6500 York Rd						25a. DATE REC'D. BY REGISTRAR JAN 03 1984	
						25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payer
returned by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Pauline Louise Clark Kay			2a. DATE OF DEATH MONTH DAY YEAR December 26, 1983			2b. HOUR 3:45 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEAR) Dep't. Buyer		12b. KIND OF BUSINESS OR INDUSTRY Store Department	
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST (unknown) Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Simmons			13e. STREET ADDRESS / ZIP CODE 100 Patricia Avenue (21090)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17 INFORMANT (son) ADDRESS Mr. Walter H. Kay (same as # 13)					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) **Cardio pulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis and Intravascular coagulation**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acute myocardial infarction**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic Renal failure, C.H.F., Chronic Bronchitis Lung disease, metabolic acidosis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-21, 1983 , to 12-26-1983 , that (I) (we) last saw the deceased alive on 3:55 PM 12-26-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. BHOWRA		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. BHOWRA		22e. ADDRESS St Agnes Hos P. Balto MD.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 83		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard, MD	
24. FUNERAL DIRECTOR NAME A B Union		ADDRESS Singleton Funeral Home Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 4 per ph.
12/29/831- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter L. Keffer			2a. DATE OF DEATH MONTH DAY YEAR 12-14-83		2b. HOUR 10²⁹ AM
3. SEX Male	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR 7 11 05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Nursing Hm.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seaman	12b. KIND OF BUSINESS OR INDUSTRY Merchant	
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1105 E. Fayette St. 21202
14. FATHER'S NAME FIRST MIDDLE LAST Jackson Keffer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Ray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1930 -35 224-50-3670		17. INFORMANT ADDRESS Mr. Wm. Keefer Moorestown, N.J. 08057	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION 12/14/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left subdural hematoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 4 1983	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Patient fell down		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Federal Hill Nursing Home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/14/83 , 19 83 , to 12/14/83 , 19 83 , that (I) (we) lost saw the deceased alive on 12/14/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel Schwab		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/14/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/19/83	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board			25. DATE REC'D. BY REGISTRAR DEC 22 1983		
ADDRESS Balto., Md.			REGISTRAR'S SIGNATURE John J. Carver		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST Virgil (Kelly) Kelley		MONTH DAY YEAR 12 1 83	
3. SEX M			4. RACE Black		2b. HOUR 5:45A M	
5. DATE OF BIRTH MONTH DAY YEAR 2 1 09			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS 21229 403 Mount Holley Street		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Purnell Kelley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brooks		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 213-05-0890			17. INFORMANT Evelyn Kelley		ADDRESS 403 Mt. Holley Street	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/83</u> to <u>12/1/83</u> , that (I) (we) lost saw the deceased alive on <u>12/1/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Gregory B. Lanpher</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/1/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gregory B. Lanpher</u>				22e. ADDRESS <u>Lutheran Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SP) BURIAL		23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.
24. FUNERAL DIRECTOR Wm C ^{ME} March F/H Inc. 1101 E North Avenue				25. DATE REC'D. BY REGISTRAR DEC 2 1983		
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>		

BP



RECEIVED
DEC 10 1963

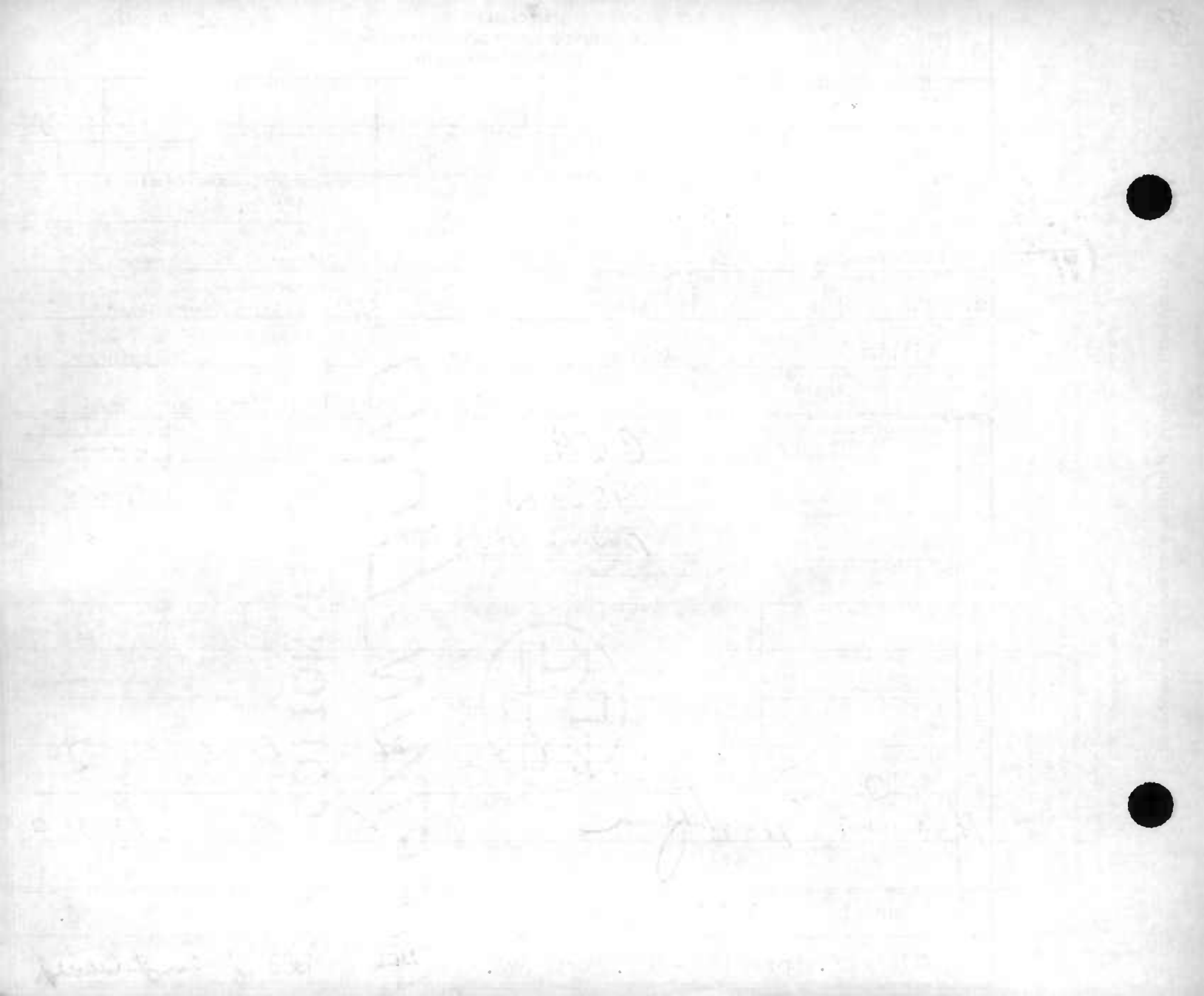


DEC 10 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Solomon Kellum					2a. DATE OF DEATH MONTH DAY YEAR 12 1 1983					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		2b. HOUR 1:28 p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cordova, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer		12b. KIND OF BUSINESS OR INDUSTRY none		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Kellum					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Inksminger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Marie Kellum 2516 Hollins Ferry Road			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last previous stroke DUE TO, OR AS A CONSEQUENCE OF (c) stroke APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 1982										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 81 , to 12-1 , 19 83 , that (I) (we) last saw the deceased alive on 12-1 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. H. H. H. H.					DEGREE			22c. DATE SIGNED 12-3-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY Newtown Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Newtown Md.			
24. FUNERAL DIRECTOR NAME William C. Brown 1206-08 W. North Ave.					25. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Camilla (Camella)		MIDDLE R.	LAST Kelly		2a. DATE KNOWN OF DEATH ESTI- MATED		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
female	black	4 1 1935	48			12 15 19 83		12	15	19	83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Md		U S A				Baltimore City,		MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Lutheran Hospital										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
Md					Baltimore		4036 Boarman Ave 21215					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
William A. Ross		Annie Carey										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
No		213-32-0621		Annie Ross 4036 Boarman Ave								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Asthma</u> 4939 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy Chief		MEDICAL EXAMINER				DATE SIGNED 12/16/83				
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St.		Balto., MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		12/21/83		Arbutus Memorial Park		Arbutus				Md		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
William C. March F/H		1101 E. North Ave		DEC 19 1983		John J. Conish						

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10

10

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY AGNES KELLY			2a. DATE OF DEATH MONTH DAY YEAR December 15, 1983			2b. HOUR 9:00 P^M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 28, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5117 Baltimore National Pike				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
13a. STATE Maryland			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5117 Baltimore National Pike	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kelly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Murray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-32-2918 A		17. INFORMANT ADDRESS Roe Stauploe Seme ae # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) Chronic emphysema of lung PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) Orthopedic deformity of spine APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15 Dec 1983</u> , to <u>15 Dec 1983</u> , that (I) (we) last saw the deceased alive on <u>15 Dec 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William J. Bryson M.D.					DEGREE M.D.		22c. DATE SIGNED 16 Dec 83		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Bryson M.D.					22e. ADDRESS 5772 Westview Mell, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/19/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Home P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228					25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PATRICK T. KELLY			2a. DATE OF DEATH MONTH DAY YEAR 12-31-83			2b. HOUR 12 noon M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH YEAR 4-20-1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Apt. 724 Hollander Ridge Apt.				12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR WORKING LIFE) Draftsman		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Kelly				15. MOTHER'S MAIDEN NAME MIDDLE LAST Unknown				13e. STREET ADDRESS / ZIP CODE Apt. 724 Hollander Ridge Apt 21237	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 304-09-2064		17. INFORMANT ADDRESS Patricia Provenzano 5040 Federal St. 21205					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio- 4292 DUE TO, OR AS A CONSEQUENCE OF Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (his hospital) attended the deceased from 11-8-83 to 1-8-84 , that (I) (we) last saw the deceased alive on 11-8-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. McPhillip			22c. DATE SIGNED 1/3/84			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. McPhillip			
22e. ADDRESS Federal Office Building, Veterans Clinic			22f. ADDRESS Federal Office Building, Veterans Clinic						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. Schamunek Funeral Home, Inc. NAME ADDRESS 3331 Brehms Lane, Balto., Md. 21213					25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Connel		

1- This certificate must be filled out once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

11

Handwritten notes and scribbles in the upper middle section.

435
Handwritten notes and scribbles in the lower section, including a large circular mark.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		8 3 3 2 5 8 6	
1. DECEASED NAME (TYPE OR PRINT) IDA Kessler		2a. DATE OF DEATH MONTH DAY YEAR 12 21 83 2b. HOUR 9:25 AM	
3. SEX F FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 03 23 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 83 84X IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN SIEGEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214 2478 33	
17. INFORMANT Dorothy Sebar - daughter - Same		ADDRESS 3305 TANEY RD. 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u> 5570 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <u>Renal failure</u>			
19a. DATE OF OPERATION 12/3/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrenous bowel	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 19 <u>83</u> , to <u>12-21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE IRA BLECKER		DEGREE MD	
22c. DATE SIGNED 12/21/83		22d. ADDRESS Sinai Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 23, 1983	
23c. NAME OF CEMETERY OR CREMATORY POSVOHLER FRIENDLY SOC.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR DEC 29 1983	
25b. REGISTRAR'S SIGNATURE John J. Givens			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the health department. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 is not marked, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DIANA B. KHOURY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1983		2b. HOUR 5:22 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Artist		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE South Carolina			13b. CITY OR TOWN Lexington	13c. STREET ADDRESS 160 Driftwood Avenue 29072	
14. FATHER'S NAME FIRST MIDDLE LAST Hasham P. Khoury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Sabbagh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 249-08-4408		17. INFORMANT ADDRESS Mr. Norman Khoury same as # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

Cardiac Arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) progressive

respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

C.M. leukemia, graft vs. host disease, bone marrow transplant

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-1-83, 19 83, to 12-15, 19 83, that (I) (we) lost saw the deceased alive on 12-15 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Laura J. Hadad	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-15-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURA J. HADAD		22e. ADDRESS JOHNS HOPKINS HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12/17/83	23c. NAME OF CEMETERY OR CREMATORY Caughman-Harman Crem.	23d. LOCATION CITY OR TOWN COUNTY STATE Lexington, South Carolina
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. 1050 York Road		25a. DATE REC'D. BY REGISTRAR DEC 20 1983	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIB

THE FARM



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 1- FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thones Kiah (Kiah)			2a. DATE OF DEATH MONTH DAY YEAR 12/26/83			2b. HOUR 1:10 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 13 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cambridge Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 4238 Norfolk Ave 21210			14. FATHER'S NAME FIRST MIDDLE LAST Charles Kiah						
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						
16b. SOCIAL SECURITY NO. 915-10-0159			17. INFORMANT ADDRESS Sadie Kiah 4238 Norfolk Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 12/24, 19 83, to 12/26, 19 83, that (I) (we) lost saw the deceased alive on 12/25, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ira T. Fine M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira T. Fine M.D.			22e. ADDRESS 222 W. Cold Spring Lane 21210						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-29-83		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN		23d. LOCATION CITY OR TOWN COUNTY STATE BALT. CITY MD.		
24. FUNERAL DIRECTOR NAME Brown-Thompson F. H.			ADDRESS 1913 W. Balt. ST.			25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE J. C. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DATE: 10/10/1918
PAGE: 1



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10/10/18

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
SEAN PATRICK KIDD			12 28 1983			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
M.	Cauc.	1 4 1971	12 YRS.			12 28 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.			U. S. A.			Baltimore City		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			Johns Hopkins Hospital			STUDENT		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Md.						Balto.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Garland			Kidd			NO		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
220-78-7358			Mr. Garland & Kidd			21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Cranio-cerebral trauma								
8147								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			5:25 P.M. 12-28-1983		Pedestrian struck by motor vehicles.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			street		3100 blk. E. Fayette St., Balto. City, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Ann M. Dixon, M.D.			Assistant			12-29-83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			12-31-83		Holly Hills Mem.		Balto. Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME			21224			DEC 30 1983		
Zanino Fun. Home - 263 S. Cookling St.						John J. Canine		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



UNITED STATES

43011-10010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 5 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Killian Paul J. Killian</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 18 83</i>			2b. HOUR <i>4:00 A.M.</i>	
1. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 3 47</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>36</i> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Md. Hospital</i>		12a. USUAL OCCUPATION (TYPE OF JOB OR MOST USUAL WORK IN LIFE) <i>Unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13a. CITY OR TOWN <i>Balto.</i> 13c. CITY OR TOWN <i>Parkville</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2920 Berwick Ave 21254</i>	

14. FATHER'S NAME FIRST MIDDLE LAST <i>William Killian</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rosalie Kavanaugh</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>215-48-3938</i>	
17. INFORMANT <i>WXR Mrs Agnes T Killian</i>		ADDRESS <i>Same As 13e</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>2020 IMMEDIATE CAUSE (a) Respiratory Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Nodular Poorly Differentiated Lymphoma</i>		<i>2/81</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/6</i> , 19 <i>83</i> , to <i>12/18</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kevin Doyle MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/18/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kevin Doyle</i>		22e. ADDRESS <i>University of Maryland Hospital</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/22/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest Veterans</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Owings Mills Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

12/1

12/2

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12/12

University of Maryland

University of Maryland

12/13

12/14

12/15

College of Agriculture

College of Agriculture

12/16

12/17

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Department of Agriculture

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12/27

University of Maryland

University of Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALBERTA Clare KING			2a. DATE OF DEATH MONTH DAY YEAR Dec. 1, 1983			2b. HOUR 5:40P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book keeper		12b. KIND OF BUSINESS OR INDUSTRY Printing	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1203 Ramblewood Rd. 21239		
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore				
14. FATHER'S NAME FIRST MIDDLE LAST Michael M. King				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret C. Koelbel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-8964		17. INFORMANT ADDRESS John M. King 7821 Aiken Ave 21234				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Advanced atherosclerotic cardiovascular disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Diabetes Mellitus

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Dr. Patricia M. D.		DEGREE M.D.		22c. DATE SIGNED 12/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRACIE V. PATRICK		22e. ADDRESS 2926 E. Cold Spring Lane			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 5, 1983		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc. ADDRESS 7110 Belair Road Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR DEC 6 1983 REGISTRAR'S SIGNATURE John J. Canfield			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1868

DOWN

20%

UP

1868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL LEON KING				Dec. 27, 1983			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 08 06 65		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 18 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13d. STREET ADDRESS MD BALT CATONSVILLE BALT 1007 ALEXANDER AVE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
4. FATHER'S NAME FIRST MIDDLE LAST MELVIN D KING SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 213-98-5792		17. INFORMANT ADDRESS Melvin & Mary King Baltimore, Md. 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) RESPIRATORY + CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) METASTASES, HYPERTENSIVE ENCEPHALOPATHY 2 mo. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
19a. DATE OF OPERATION OCT 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED COLOSTOMY, EXPLORATORY, FEEDING GASTROSTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from Nov. 1, 19 83, to Dec. 27, 19 83, that (X) (we) lost saw the deceased alive on above (we) (did) (X) (not) view the body after death.							
22b. SIGNATURE Janice L. Dec-Bienkowski MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANICE L. DEC-BIENKOWSKI MD				22e. ADDRESS 900 S. CATON AVE-BALTO., MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/1983		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NUTTER & SONS 2501 Gwynns Falls NAME ADDRESS Funeral Home Inc. Baltimore, Md. 21216				DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE DEC 29 1983 John J. Conner			

BALTIMORE CITY

SAINT AGNES HOSPITAL

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4-300 S. CATON AVE-BALTO., MD 21239

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOYCE Y KING						2a. DATE OF DEATH MONTH DAY YEAR 12 20 83		2b. HOUR 2:10P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 8 38		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 192 Cherrydell Rd. 21228			
14. FATHER'S NAME FIRST MIDDLE LAST Luther Strausser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Macciola							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-36-6200		17. INFORMANT ADDRESS Herbert D. King 192 Cherrydell Rd. 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest 2024 DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) hairy cell leukemia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mos 2 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 83 , to 12/20 , 19 83 , that (I) (we) last saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Douglas Proops				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS PROOPS				22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

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1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
MAE		C		KING				12-21-83		14		58		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		White		MONTH 7 DAY 22 YEAR 05		78 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
MD		USA				BALT CITY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALT.		UNIV. OF MD. HOSP.		Domestic		Homes													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
MD				BALT CITY						306 S. NORTON ST.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST		FIRST MIDDLE LAST																	
John J. Adams		Adelaide Breighner																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		217-22-0232		BETTY BLACK		1502 McHARRY ST. BALT.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
5609		CARDIO PULMONARY ARREST		GASTROINTESTINAL BLEEDING & HYPOTHERMIA		ABDOMINAL OBSTRUCTION OR PERFORATION?				3 HOURS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
HYPOTHERMIA																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I, this hospital) attended the deceased from <u>DEC 21</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>DEC 21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED													
J. Terence Mc Muller MD						12/21/83													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
J. Terence Mc Muller MD		UNIV OF MD. HOSP.																	
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		12-24-1983		London Park Cem		Balt. Md. 21223													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

EARL FRANKLIN KIRK

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL F. KIRK			2a. DATE OF DEATH MONTH DAY YEAR 12-23-83		2b. HOUR 4:50 P.M.
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-30-12	6. AGE (IN YEARS LAST BIRTHDAY) 71	7. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
7a. BIRTHPLACE (COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEW CAR MANAGER		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FRANKLIN FREDERICK KIRK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOUISE LIST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 215-10-4831		17. INFORMANT ADDRESS VERA E. KIRK 2015 CEDAR CIRCLE DR. 21228	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) PULMONARY EDEMA + CONGESTION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b) PROBABLE ACUTE MYOCARDIAL INFARCT

HOURS

DUE TO, OR AS A CONSEQUENCE OF

(c) GENERALIZED ATHEROSCLEROSIS

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE JAMES E. TAYLOR		DEGREE M.D.	22c. DATE SIGNED 12/24/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR		22e. ADDRESS ST AGNES HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/28/83	23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE WOOLLAWN MARYLAND
24. FUNERAL DIRECTOR NAME LERON M. & RUSSELL C. WITZKE ADDRESS 1630 EDMONDSON AVENUE BALTIMORE MD. 21228		25. DATE RECD. BY REGISTRAR DEC 28 1983	

• • •

CHICKADEE BALTIMORE MAYNARD

[UNIT 2]

12710497

318-10-0215

5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Nellie E. Kirk								Dec. 17, 1983										M	
3 SEX		4 RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		white		Sept. 7, 1896								87		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH										MD.	
Maryland		USA						Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		2211 W. Rogers Avenue		Retired															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 W. Rogers Ave 21209											
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
William Walton		Florence Fuller																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS													
NO		220 14 9819		The Wesley Home		same													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):		4360		Acute Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		acute.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(b) Cerebrovascular Disease		years													
		DUE TO, OR AS A CONSEQUENCE OF		(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (1) (this hospital) attended the deceased from FEB 1, 19 79, to 12/18, 19 83, that (1) (we) lost saw the deceased alive on 12/15, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) did not view the body after death.		22b. SIGNATURE Robert E. Roby M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-19-83											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT E. ROBY, M.D.		22e. ADDRESS 8817 Belair Rd. 21236																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
						Dorsey		Howard Co.		Md.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Burgee Funeral Home 3631 Falls Road 21211		DEC 20 1983		John D. Smith															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



4-237



DHMH - 16 50M 4/B2
(VRA 15, 4)

REG. NO.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
George Kirschbaum		12/31/83		7p M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE	white	MAR. 4, 1892		91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
PENNSYLVANIA		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		SINAI HOSPITAL		BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		SINAI HOSPITAL		FLORIST	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
FLOWERS		4000 FORDS LA., APT. 1C 21215		BALTO., MD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
JOSEPH KIRSCHBAUM		SARAH		NO	
17. INFORMANT		18. SOCIAL SECURITY NO.		19. DATE OF OPERATION	
MRS. SARA WOLF		217-20-3666		3212 HATTON RD. BALTO., MD 21208	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		21. TIME OF INJURY		22. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
1850 SEPSIS SHOCK		P.M. 19		DUE TO, OR AS A CONSEQUENCE OF	
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
1850		prostate Ca metastatic to liver + bone		1850	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		23. DATE		24. NAME OF CEMETERY OR CREMATORY	
		JAN. 2, 1984		BNAI ISRAEL	
25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		27. DATE SIGNED	
JAN 5 1984		John J. Connel		12/31/83	

2000 • J. Neurosci., September 13, 10(18):6900–6907 • 6907

• *Journal of Management Education* 31(10):1033-1046

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
LILLIAN J. KIRSCHKE						12 1 83				2:15p	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		WHITE		8 MONTH 6 DAY 95		88 YRS		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTIMORE		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		ST AGNES HOSPITAL				HOMEMAKER			---		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTIMORE		BROOKLYN PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		105 15TH AVENUE, 21225			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
ROLAND MORRIS				ANN WHITMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				218-01-1948		MARION KIRSCHKE 105 15TH AVENUE, 21225					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke + C.H.F</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>H.B.P</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/6/83</u> to <u>12/1/83</u> , that (I) (we) lost saw the deceased alive on <u>12/1/83 at 2 PM</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
<u>Singh</u>									<u>12/1/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
<u>DR. SINGH</u>			<u>900, Caton Ave, S A Hosp, Baltimore, MD</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			12-05-83		LOUDON PARK		BALTIMORE CITY MARYLAND				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						DEC 5 1983		<u>John J. C... ..</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA MARIE KLACIK						2a. DATE OF DEATH MONTH DAY YEAR 12 10 83		2b. HOUR 3:45 am			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 17 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAUNDRY		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 28 S. CARROLLTON AVE., 21223			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN JUBB		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY CARRIGAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-16-0342		17. INFORMANT HELEN F. ROSSITER 28 S. CARROLLTON AVENUE 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Approx. 2 days.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Congestive Heart Failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>83</u> , to <u>12/10</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ronald Sakamoto</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/10/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Sakamoto		22e. ADDRESS Mercy Hosp, 301 St. Paul Place, Bal. H. 21202									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-13-83		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>					

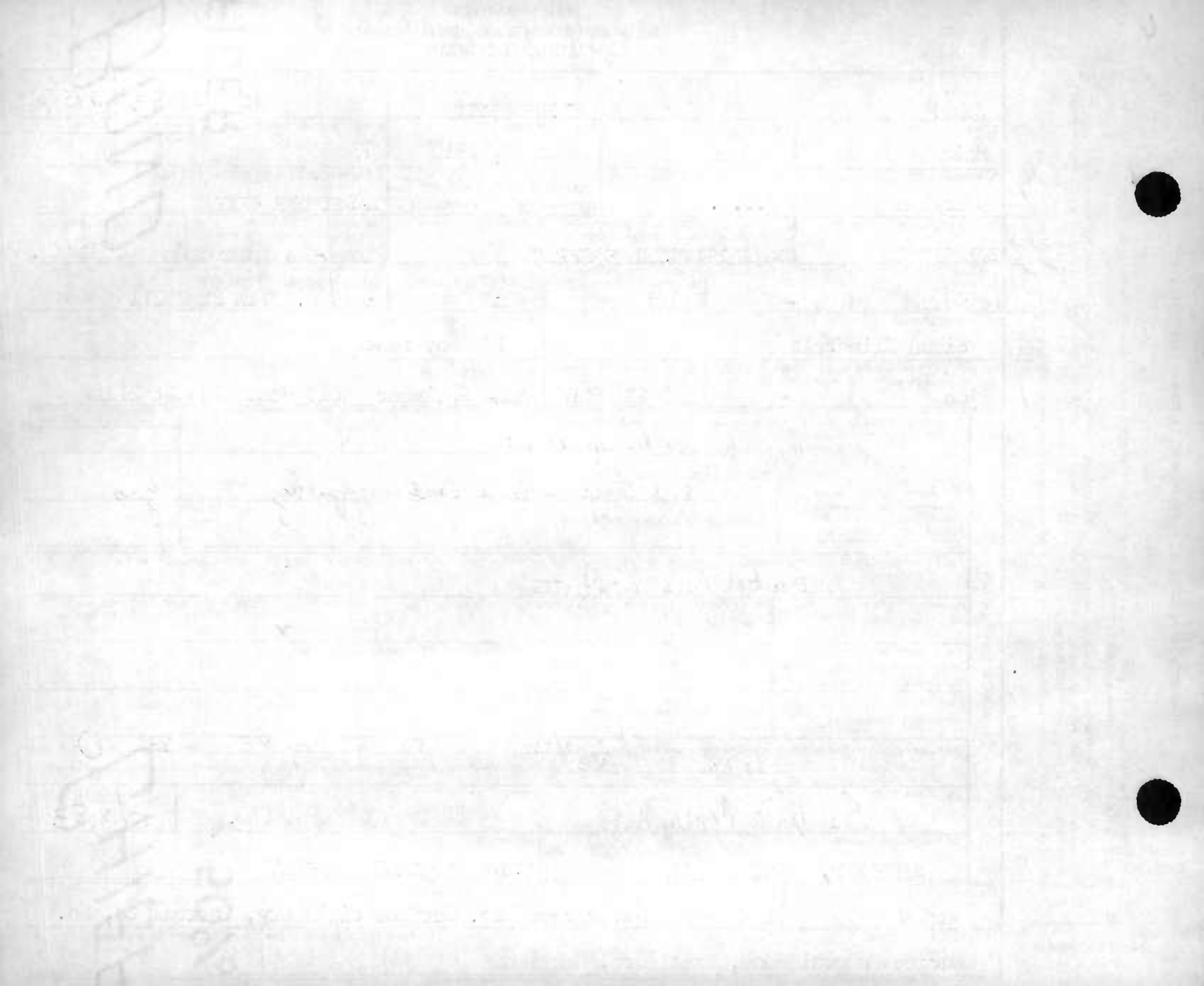
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for necropsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) SIMON					FIRST C		MIDDLE KLINFELTER		LAST		2a. DATE OF DEATH MONTH DAY YEAR 12 28 83		2b. HOUR 4:15 PM	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1910			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman Gas Construction			12b. KIND OF BUSINESS OR INDUSTRY Utility Co.			
13a. STATE Maryland			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1019 W. 37th St 21211					
14. FATHER'S NAME FIRST MIDDLE LAST Simon Klinefelter					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida May Lentz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -			17. INFORMANT Anna Springer			ADDRESS 1019 West 37th St 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopap Arrest 4148 DUE TO, OR AS A CONSEQUENCE OF (b) and Stage ischemic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) gas												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Interstitial lung infiltrate														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 83 , to 12/28 , 19 83 , that (I) (we) last saw the deceased alive on 12/28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Sander M. Cohen MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/28/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANDER M. COHEN MD			22e. ADDRESS UNION MEMORIAL HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-83			23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll Co, Md.					
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, Baltimore, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 3 1984			25b. REGISTRAR'S SIGNATURE John J. Carish					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JAMES R. KNAPP, JR.				2a. DATE OF DEATH MONTH DAY YEAR 12-14-83				2b. HOUR 10 ⁴⁵ M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 1 48		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Controle Tech.		12b. KIND OF BUSINESS OR INDUSTRY Balto. G.&E. Co.			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2606 Myrtle Avenue 21227	
14. FATHER'S NAME FIRST MIDDLE LAST James R. Knapp, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hughes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-50-6396		17. INFORMANT ADDRESS Alice A. Knapp 2606 Myrtle Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse CMV pneumonia ov ARDS. 9 days DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis - CMV 9 days.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION 10-29-83				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Renal Failure				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-14, 1983, to 12-14, 1983, that (I) (we) lost saw the deceased alive on 12-14, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David A. Crist MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-14-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A Crist				22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/19/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Avenue						25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carls			

U.S. DEPARTMENT OF THE ARMY
HEADQUARTERS, WASHINGTON, D.C.

1. SUMMARY

2. REFERENCES

3. DESCRIPTION OF THE PROJECT

4. STATEMENT OF THE PROBLEM

5. STATEMENT OF THE OBJECTIVES

6. STATEMENT OF THE SCOPE

7. STATEMENT OF THE SIGNIFICANCE

8. STATEMENT OF THE RESEARCH DESIGN

9. STATEMENT OF THE RESULTS

10. STATEMENT OF THE CONCLUSIONS

11. STATEMENT OF THE RECOMMENDATIONS

12. STATEMENT OF THE REFERENCES

13. STATEMENT OF THE APPENDICES

14. STATEMENT OF THE DISTRIBUTION

15. STATEMENT OF THE SUMMARY

16. STATEMENT OF THE CONCLUSIONS

17. STATEMENT OF THE RECOMMENDATIONS

18. STATEMENT OF THE REFERENCES

19. STATEMENT OF THE APPENDICES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rose M Knapple</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 26 83</i>			2b. HOUR <i>3:15</i> M	
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 1 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>71</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Idaho</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balt.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, ONE STREET ADDRESS) <i>23150 Greenleaf Balt MD</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Secretary</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>NJ</i>				13b. COUNTY <i>Ocean</i>		13c. CITY OR TOWN <i>Tuckerton</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Vincent</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marin Margues</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>061-03-0959</i>		17. INFORMANT ADDRESS <i>27 E Boat Dr. ES052</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1991 IMMEDIATE CAUSE (a) *cardio pulmonary arrest*
DUE TO, OR AS A CONSEQUENCE OF
(b) *metastatic cancer*
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>11/11/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>left colon mass</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <i>Dr. H. W. H. H. H.</i> attended the deceased from <i>10/22/83</i> to <i>12/26/83</i> , that <i>we</i> last saw the deceased on <i>12/26/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do not) view the body after death.							
22b. SIGNATURE <i>Harold W. H. H.</i>		DEGREE <i>MD</i>		ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/26/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NUDEL MAN</i>		22e. ADDRESS <i>22 S. Greene St Balt MD 21209</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-30-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KENSICO</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>VAL HALLA N.Y.</i>	
24. FUNERAL DIRECTOR NAME <i>HARRY WITZKE</i>				ADDRESS <i>4112 COLUMBIA RD.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1983</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. G. G.</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN F KNOWLES				2b. HOUR 5:40 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 5, 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md 13b. COUNTY Baltimore 13c. CITY OR TOWN Parkville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST ? Kurowska				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-14-8393		17. INFORMANT ADDRESS Mrs Margaret M Kidd Same As 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a): Cardiac Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b): Recurrent cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c): CHF ASCVD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12-5-83 , to 12-5-83 , that (I) (we) lost saw the deceased alive on 12-5-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rosita R. Cruz M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-5-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSITA R. CRUZ M.D.				22e. ADDRESS GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified on page 4.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Percy Deo Kohler						2a. DATE OF DEATH MONTH DAY YEAR 12 07 83		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 4 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wyman Park Helath System, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Serviceman		12b. KIND OF BUSINESS OR INDUSTRY US Navy			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 Riversie Road 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Emile Kohler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anita Convient						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1922-45		17. INFORMANT Elizabeth S. Kohler, Wife		ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4413 IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 3 hrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recent myocardial infarction and valve operation											
19a. DATE OF OPERATION 12/7/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Abdominal Aortic Aneurysm				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Marrone MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/7/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. MARRONE				22e. ADDRESS Wyman Park Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/12/83		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR Gardzinski Funeral Home PA				25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

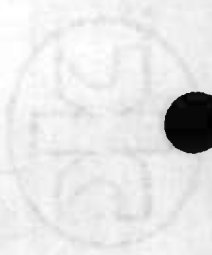
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LAST KORECKY			2a. DATE OF DEATH MONTH DAY YEAR 12/8/83			2b. HOUR 6 ⁰⁰ AM			
3. SEX F Female		4. RACE W Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 7 13 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN L. DEATON MED CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 611 S. Charles St. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rhuby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-74-4159		17. INFORMANT ADDRESS Anna Russell 19 N. Rose St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Gangrenous (L) foot APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks 4 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/22 19 83, to 12/8 19 83, that (I) (we) last saw the deceased alive on 12/8 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Deborah Homyson MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah Homyson				22e. ADDRESS J.L. Deaton Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS B. Dabrowski & Son 2818 E. Baltimore St. DEC 12 1983									

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

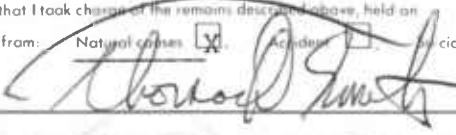

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Walter Korpisz			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/11/83			2b. HOUR M		
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 26 1918	6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD 12/11/83	2d. HOUR 2:00 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bd.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3111 E. Baltimore St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Checker		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Korpisz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Wisniewski			16. SOCIAL SECURITY NO. 217-07-9113		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. INFORMANT ADDRESS Alfred Korpisz 4 N. Linwood Ave.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE 			TITLE (SPECIFY) Dep. Chief M.D.			DATE SIGNED 12/12/83		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-83		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS John M. Weber & Sons Inc. 401 S. Chester St.				25a. DATE REC'D. BY REGISTRAR DEC 14 1983		25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Henrietta Mary Kosker			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1983		2b. HOUR M M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Dosch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Byrad			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-01-4440		17. INFORMANT ADDRESS Catherine M. Smith 4313 Willshire Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10/20/73 to 12/22/83 , that (I) (we) lost saw the deceased alive on 12/3/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Albert C. Herrmann, M.D.		DEGREE M.D.		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert C. Herrmann, M.D.		22e. ADDRESS 5525 Belair Road Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland		25. IF REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 27 1983 John J. Conish			

November 22, 1987

Monday

Barry

Memphis

34

Feb. 14, 1989

White

Female

Baltimore, Md.

x

U.S.A.

Married

Memphis

Good Samaritan Hospital

Baltimore

417 Wilshire Ave. 21008

x

Baltimore

Married

Barry

Barry

Barry

Barry

210-01-1100 Catherine M. Smith 417 Wilshire Ave.

No

2 WKS

MYOCLONAL DISCHARGE

ACTING CLINICAL DIRECTOR

DIAGNOSTIC SECTION

MYOCLONUS

X

12/22

12/20

12/13

12/23/87

✓



Albert G. Harrison, M.D. THE JOINT BOARD BALTIMORE, MD.

Baltimore

Dec. 27, 1987 Shared Dept of Johns Baltimore

Barry

Donald J. Cook, Inc. Baltimore, Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lena Krause			2a. DATE OF DEATH MONTH DAY YEAR 12 30 83			2b. HOUR 2 06 AM	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 02 20 00	6. AGE (IN YEARS LAST BIRTHDAY) 83 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MD			13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS APT. A 3933 Clarks Ln 21215		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB MARGET		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE SHEMER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-26-6147		17. INFORMANT ROSALIE KRAUSE APT. 14 3 ENGLEWOOD AVE. BROOKLINE, MA 02146			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Complete heart block

DUE TO, OR AS A CONSEQUENCE OF

4269
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

thoracic hemorrhage

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 12/28, 19 83, to 12/30, 19 83, that (1) (we) lost saw the deceased alive on 12/30, 19 83, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.							
22b. SIGNATURE Deborah Ward MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah Ward MD		22e. ADDRESS Sinai Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC. 30, 1983	23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH	23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JAN 5 1984	25b. REGISTRAR'S SIGNATURE Sam E. Conrad

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY KRAVITZ		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4, 1983		2b. HOUR 9:30 PM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3125 BANCROFT RD. APT. E (21215)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JACOB GILMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-01-2596		17. INFORMANT ADDRESS CROSS COUNTRY MANOR APTS. PHILIP KRAVITZ 3125 BANCROFT RD. APT. E (21215)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>5140</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen H. Cassen</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>12/5/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen H. Cassen M.D.</u>		22e. ADDRESS <u>600 Reisterstown Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 7, 1983		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. XXXXX INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>		25c. DATE REC'D. BY REGISTRAR DEC 13 1983	

BP



RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

2062

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Asher H. Kreider			2a. DATE OF DEATH MONTH DAY YEAR 12-29-83		2b. HOUR 6 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-13-01		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) 2946 Harford Rd.			12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Ret. Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Kreider				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Hoffer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 191-12-1760		17. INFORMANT ADDRESS Melvin Kreider, Same as 13c				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

CARDIO PULMONARY ARREST**(b) CARCINOMA OF LUNG**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

COPD

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-27-83 to 12-29-83 , that (I) (we) last saw the deceased alive on 12-27-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Rao				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-30-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Rao, M.D.				22e. ADDRESS 3128 Harford Rd.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, check any injury, or other traumatic event, the medical certificate must be filled out at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Lillian						Krikscunas		ESTIMATED <input checked="" type="checkbox"/>		12		30		1983		M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Female	White	12 16 15		69 YRS.						1		2		1984		10:20 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.A.				Baltimore City, MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		1810 Spence Street		Secretary		Grace Cem.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1810 Spence Street 21230											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Vincent		Kirkscunas		Amelia		Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		216-07-0560		June Potter		1413 Kahoe Rd. 21050													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																			
4292 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .																			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Thomas D. Smith</u> TITLE (SPECIFY) <u>Deputy Chief</u> MEDICAL EXAMINER																DATE SIGNED <u>1/3/84</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Thomas D. Smith, M.D.</u> ADDRESS <u>111 Penn St. Balto., MD.</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				1/6/84				Most Holy Redeemer				Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS 21229																25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.																JAN 5 1984			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 6 1 2

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Stanley Kruba, Sr.		12 15 83		6:10 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))		
Male	White	6 13 1922	61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania	U.S.A.			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	University Hospital	Mechanic-Continental Can			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1929 Searles Road 21222	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
George Kruba		Rosalia Broda		8136 Midhaven Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
Yes	WW II	232-44-1042 Stanley Kruba, Jr. - Balto., MD. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute biventricular failure post</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary artery bypass grafting</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Dec 15, 1983		Coronary Artery Disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 14</u> , 19 <u>83</u> , to <u>Dec 15</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Dec 15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>B. Justin Kim</u>		M.D.		Dec 15, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>B. Justin Kim</u>		<u>Univ of Maryland Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	23e. DATE REC'D. BY REGISTRAR	
Burial	12/17/83	Meadowridge	Dorsey Maryland	DEC 20 1983	
24. FUNERAL DIRECTOR NAME 7922 Wise Avenue Dundalk, MD. 21222			25a. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) William KRYSIAK					2a. DATE OF DEATH MONTH 12 DAY 19 YEAR 83 2b. HOUR 9:10 P M					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 02 DAY 10 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (LIST IN SUCH FACILITY, GIVE STREET ADDRESS) Stina Hospital of Balto.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) steel worker		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel		
13a. STATE Maryland					13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST James J. MIDDLE Krysiak LAST 					15. MOTHER'S MAIDEN NAME FIRST Sophia MIDDLE K. LAST Micka					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW 2					16b. SOCIAL SECURITY NO. 213-07-4957		17. INFORMANT Mr. William Krysiak Jr 20 Hawthorne Avenue Baltimore, MD. 21208			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4920 DUE TO, OR AS A CONSEQUENCE OF (b) COPD & cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/15/83 10yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/15/83 to 12/19/83 , that (I) (we) lost 12/19/83 saw the deceased alive on 12/19/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.										
22b. SIGNATURE M. J. Gover						DEGREE		22c. DATE SIGNED 12/19/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRNA I. GOVER						22e. ADDRESS 5861-D western Run DR. Balto				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-23-83		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors Inc. ADDRESS 8728 Liberty Road Randallstown, MD. 21133						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Connel		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR ITEM # 17 FILM #G586
STATE REGISTRAR 12/28/83 jp

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alexander G. Kuchta			2a. DATE OF DEATH MONTH DAY YEAR 12-8-83		2b. HOUR M
3. SEX male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 4 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISS.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13 S. CASTLE ST		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 13 S. CASTLE ST. 21231
14. FATHER'S NAME FIRST MIDDLE LAST William KUCHTA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CHARLOTTE LIVINIA KUCHTA 13 S. CASTLE ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph B. Kligman M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph B. Kligman, M.D.				22e. ADDRESS 9000 Franklin Square Dr., Balt. MD.	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 12/12/1983	23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		23d. LOCATION (CITY OR TOWN) COUNTY STATE BALTIMORE MD.
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983	25b. REGISTRAR'S SIGNATURE John J. Carver

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

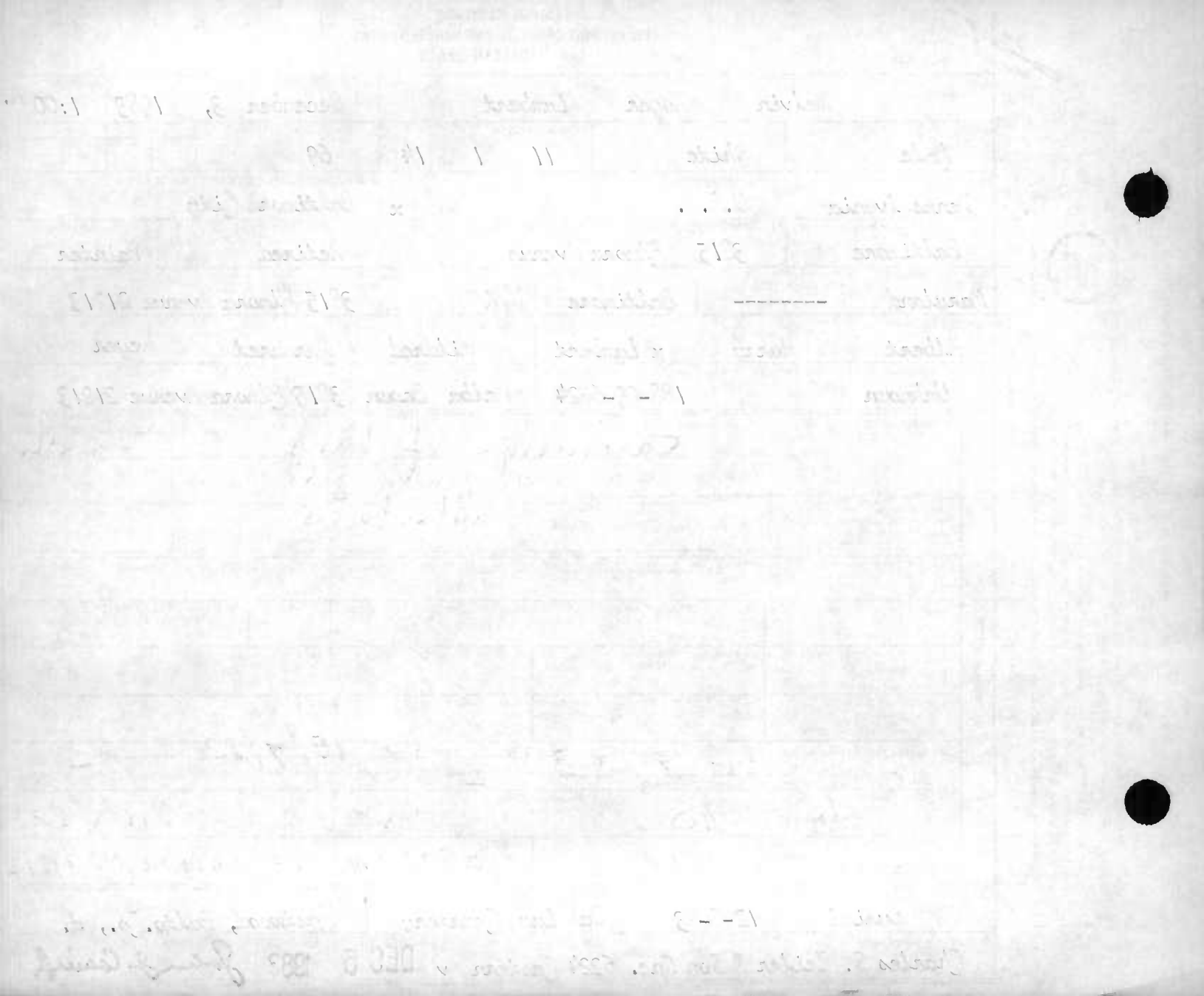
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Melvin Roger Lambert		December 3, 1983		1:00 M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	69	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	3815 Elmora Avenue		Retired		Painter
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Albert		Mildred Margaret Keyer		Unknown	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
188-09-6824		Melba Brown		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>w/ generalized metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> 19 <u>83</u> , to <u>10/7/83</u> 19 <u>83</u> that (I) (we) lost saw the deceased alive on <u>Oct 7</u> 19 <u>83</u> (and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Felix Tan, M.D.</u>				<u>12/5/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
FELIX TAN, M.D.		3800 ELDON AVE, BALTIMORE, MD 21213		DEC 5 1983	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-6-83	Oak Lawn Cemetery	Eastwood, Balto. Co., Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles S. Zeiler & Son Inc. 6224 Eastern Av		DEC 5 1983		<u>John J. Conner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LATITIA LAMENDOLA				2a. DATE OF DEATH MONTH DAY YEAR 12-18-83		2b. HOUR 6 35 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 27 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Female		7b. CITIZEN OF WHAT COUNTRY? White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Keeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 125 Dorchester Rd 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Lamendola				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary G Sortino			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-8423		17. INFORMANT ADDRESS Rosemary Wooldridge Same As 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative bacterial infection 0418 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 18 , 19 83 , to Dec 18 , 19 83 , that (I) (we) last saw the deceased alive on December , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sam J. Wark				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Huer, Steven J				22e. ADDRESS Baltimore City Hospital, Easton Ave, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc ADDRESS 5302 Harborhead				25a. DATE REC'D. BY REGISTRAR DEC 20 1983 25b. REGISTRAR'S SIGNATURE John J. Davis			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#17 G593 7/3/84 CW

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Lamont			2a. DATE OF DEATH MONTH DAY YEAR 12 29 83			2b. HOUR 1:10pM			
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 8 16 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4255 Nicholas Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4255 Nicholas Avenue 21206	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 181-09-5566		17. INFORMANT ZAKRZEWSKI Ms. Helen Zack		ADDRESS 3816 Echodale Ave. Balto., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minute 20 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ira A. Morris</i> DEGREE						22c. DATE SIGNED 1/7/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ira A. Morris						22e. ADDRESS Central Maryland Medical Grp. 4419 Falls Road, Baltimore, Md. 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12-29-83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board, Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR 1 JAN 13 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>	

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RECEIVED
JAN 10 1901
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE
WASHINGTON, D.C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for an improvement in the method of cultivating cotton.

The application in question is one of the many which are received by the Department from time to time, and it is the policy of the Department to refer all such applications to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
J. B. HARRIS
Assistant Secretary



RECEIVED
JAN 10 1901
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
AVA M. LANDRUM		12 - 30 - 83		3:17 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR	69	IF UNDER 2 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
S.C.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	BALTO City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	UN. OF MD HOSP		-	-	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
MD	Baltimore	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE		
Wiley	MARTIN	CHARIE	2203 Durston ST 21217		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
	250-20-9459	ARTHUR M. LANDRUM Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) hypotension					
4120 DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FIBRILLATION					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Idioventricular Rhythm					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: H/O MYOCARDIAL INFARCTION, HYPERTENSION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/30, 1983, to 12/30, 1983, that (we) lost saw the deceased alive on 12/30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE			22c. DATE SIGNED	
John A. Vitarello Jr. MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
John A. Vitarello Jr MD	UNIV. Maryland Hospital				
23a. BURIAL, CREMATION, REMOVAL (CITY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	1/5/84	Crowsville NAT	Crowsville MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bailey T.H. 1348 N. CALHOUN ST		JAN 4 1984		John J. Canfield	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Cline P. Lane			2a. DATE OF DEATH MONTH DAY YEAR Dec. 20, 1983		2b. HOUR 1:30 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4214 Curtis Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Coverer	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4214 Curtis Ave. 21226	
14. FATHER'S NAME FIRST MIDDLE LAST John Lane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Sharp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 244-10-9697	17. INFORMANT ADDRESS M. Christine Lane same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) <u>Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (his hospital) attended the deceased from <u>12/18/81</u> , 19____, to <u>12/19/83</u> , 19____, that (1) (we) lost saw the deceased alive on <u>11/12/83</u> , 19____, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. J. Folkenner, M.D.		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Folkenner		22e. ADDRESS Mercy Hospital,			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 22 Dec. 83	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. MD	25a. DATE REC'D. BY REGISTRAR DEC 23 1983	
24. FUNERAL DIRECTOR NAME James S. Kirkley		ADDRESS Glen Burnie MD.		25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Main body of handwritten text, organized into several horizontal lines. The text is extremely faded and mostly illegible, appearing as light gray strokes against the white background.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RONIE MAE LANE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 6, 1983		2b. HOUR 8:15A M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 27 1909		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Middlesex Co. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Pa.		13b. COUNTY Phila.		13c. CITY OR TOWN Phila.		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Greenwood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Pratt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 098 20 2584		17. INFORMANT ADDRESS Thelma Gamble 132 Allendale St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pleural effusion DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic breast Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 83 , to 12/6 , 19 83 , that (I) (we) lost saw the deceased alive on 12/6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bedri Yousif		DEGREE		22c. DATE SIGNED 12/6/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEDRI YOUSIF		22e. ADDRESS Oncology Center Johns Hopkins Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Eden		
24. FUNERAL DIRECTOR NAME Marshall P. Hayes		ADDRESS 638 N. Gilmer St.		25a. DATE REC'D. BY REGISTRAR DEC 8 1983		
				25b. REGISTRAR'S SIGNATURE John J. Lohr		

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1 - FOR
STATE
REGISTRAR

REG. NO.

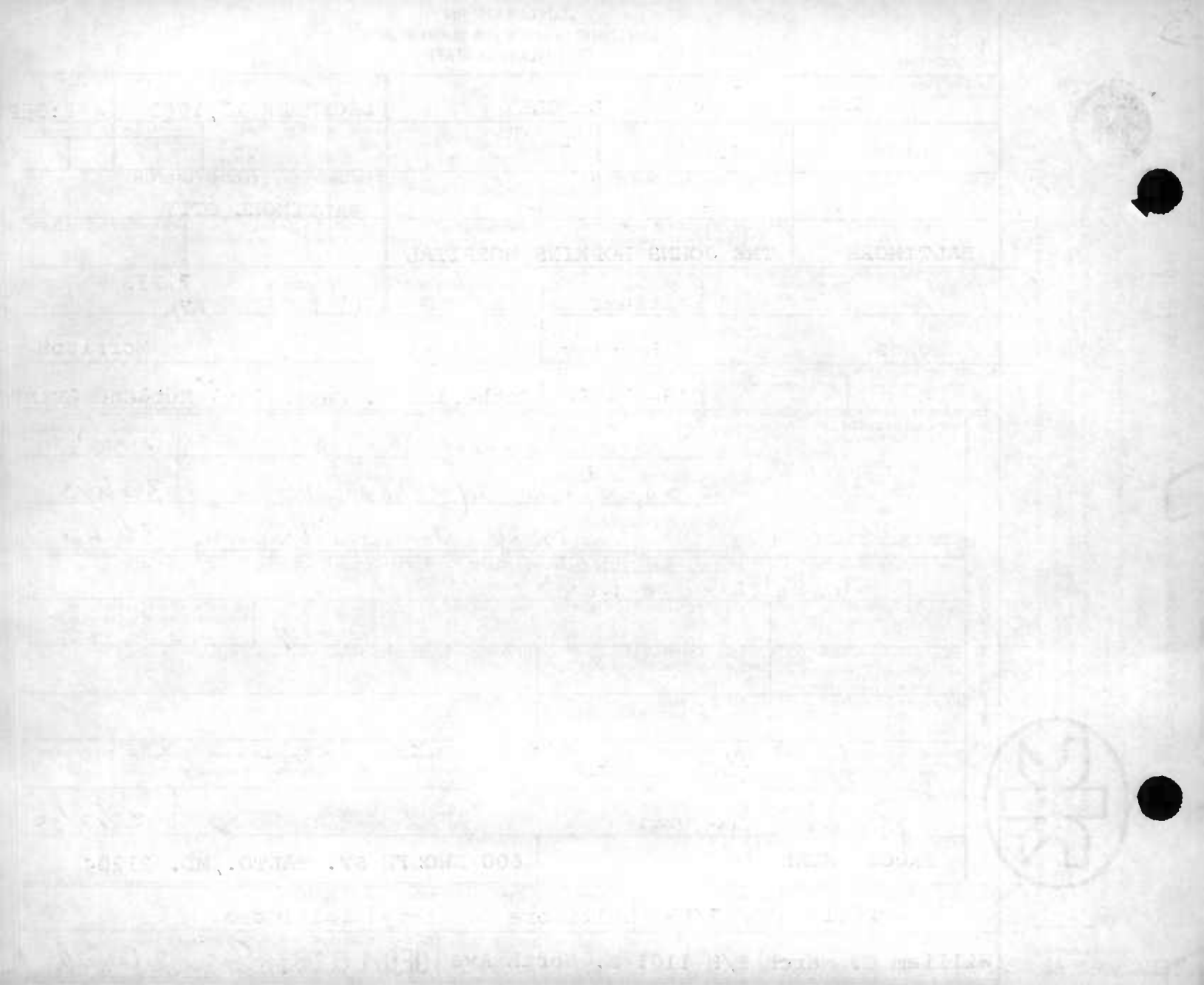
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Henry Mack		DECEMBER 13, 1983								5:35P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male		black		MONTH DAY YEAR 7 17 1904		79 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S. C.		U S A				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL									
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		21213			
Md		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1207 Rutland Ave					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST Moses		FIRST MIDDLE LAST Harriett R. Morrison		No		213-07-6862		Catherine L. Davis		1207 Rutland Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration of blood</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>massive variceal hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u> <u>30 hrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>alcoholic cirrhosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>83</u> , to <u>12/13</u> 19 <u>83</u> , that (I)/(we) last saw the deceased alive on <u>12/13</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Bruce Kone, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/13/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE KONE		22e. ADDRESS 600 NWOLFE ST. BALTO., MD. 21205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		12/17/83		Baltimore Cemetery		Baltimore				Md	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William C. March F/H 1101		E. North Ave		DEC 15 1983		<u>John J. Carver</u>					

RETURNED TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

RETURNED TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) George W Larkins						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-24-83		2b. HOUR M 12:15			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 6 1935	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 48	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-24-83		2d. HOUR M 12:15			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Annapolis, Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital-STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing Supervisor Marriott		12b. KIND OF BUSINESS OR INDUSTRY Corp			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6908 Digby Road Baltimore, Maryland 21207			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Larkins Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida E. Nelson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam 217-30-4709		17. INFORMANT Lagretta Larkins		ADDRESS 6908 Digby Road Balto. Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:xx 12/24/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver/auto/lost control/submerged in water							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2000Blk Annapolis Rd, Baltimore City, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 12/25/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/1983		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS NUTTER & SONS 2501 Gwynns Falls FUNERAL HOME INC. Baltimore, Maryland 21216				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3 AND 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PHYLLIS L. LAROCHELLE						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12-9-83		2b. HOUR 3:45A			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 56	6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 12-9-83		2d. HOUR 3:45A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY High's			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 549 S. 47th Street 21224			
14. FATHER'S NAME FIRST Gerald MIDDLE E. LAST Sneary, Sr.				15. MOTHER'S MAIDEN NAME FIRST Clarice MIDDLE L. LAST Dorsey				16. SOCIAL SECURITY NO. 216-62-4855			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		17. INFORMANT Gerald E. Sneary, Sr. - Balto. MD. 21224		ADDRESS 549 S. 47th St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of aorta 8123 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 2:30AM MONTH 12 DAY 9 YEAR 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger of motorcycle/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) intersection			21f. LOCATION STREET Kenwood and Fleet Sts. CITY OR TOWN Balto., COUNTY Md. STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) Assistant			DATE SIGNED 12-9-83		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 13 1983			25b. REGISTRAR'S SIGNATURE John J. Canish		
7922 Wise Avenue Dundalk, MD. 21222											

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RECEIVED
JAN 21 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Baby Gerl Lawrence			2a. DATE OF DEATH MONTH DAY YEAR 11 28 83			2b. HOUR 1 08 A M						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 23 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 5		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. STATE Maryland			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2606 Roslyn Avenue 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Leon Pitka				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Lawrence								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Dorothea Lawrence			ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emphysema & hemorrage 7651 DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline membrane disease DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/23 1983, to 11/28 1983, that (I) (we) last saw this deceased alive on 11/28 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE William C. Hicken MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/29/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. HICKEN, MD				22e. ADDRESS St Agnes Hosp.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/14/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD				
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25b. DATE REC'D. BY REGISTRAR FEB 14 1984						
						25a. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

BP



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "check", "amount", and "total" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH LAWSON			2a. DATE OF DEATH MONTH DAY YEAR 12-14-83			2b. HOUR 1:30 P.M.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 8-16-45		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Memphis Tenn		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secures Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1820 W. Baltimore St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Lane Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Lee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 408-22-1390		17. INFORMANT ADDRESS Costella Spencer - 1820 W. Balto. St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 5860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) End stage Renal Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary Heart Failure, ASCVD									
19a. DATE OF OPERATION 10/11/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1940 W. BALTIMORE ST, BALTIMORE MD 21223					
22a. I certify that (I) (this hospital) attended the deceased from 10/11/83 to 12/14/83 , that (I) (we) last saw the deceased alive on 12/14/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Juan A. Beltran				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. BELTRAN				22e. ADDRESS 1940 W. BALTIMORE ST, BALTIMORE MD 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD 21223			
24. FUNERAL DIRECTOR NAME Brown-Thompson F.H.				ADDRESS 1913 W. Balto St		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous research, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry H. Leaf			2a. DATE OF DEATH MONTH DAY YEAR 12/6/83			2b. HOUR 715 M				
3. SEX M		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 04/09/99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 5 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stationary Engineer		12b. KIND OF BUSINESS OR INDUSTRY Medical School		
13a. STATE Md.			13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5518 Mattfeldt Ave 21209	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Henry Leaf				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dover Larmore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			16b. SOCIAL SECURITY NO. 216 10 9654		17. INFORMANT ADDRESS Gwendolyn Hawkins 5518 Mattfeldt Ave 21209					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4100 DUE TO, OR AS A CONSEQUENCE OF (b) R/O MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (U) (this hospital) attended the deceased from 12-6-83 , to 12-6-83 , that (I) (we) last saw the deceased alive on 12-6-83 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (we) did/did not view the body after death.							
22b. SIGNATURE Patricia A. Snello				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SNELLO				22e. ADDRESS Sinai Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-09-83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Balto Co., Md.	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, Baltimore, Md				25. DATE REC'D. BY REGISTRAR DEC 8 - 1983		25b. REGISTRAR'S SIGNATURE John J. Lough	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Herbert S. Lee, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/09/83</i>			2b. HOUR <i>12:11 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 29 25</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>hotel</i>	
13a. STATE <i>Balt., md</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balt.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Herbert S. Lee</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Spencer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT ADDRESS <i>Mrs. Verna L. Day-4502 Kathland Ave</i> 21207			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hemaphysis</i> <i>2020</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>poorly differentiated nodular lymphoma - class IV</i> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>squamous cell ca w/ mets unknown primary</i> <i>Acid</i> <i>uric acid</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Risa Beth Burns</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/9/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Risa Beth Burns MD</i>		22e. ADDRESS <i>Sinai Hospital of Balt.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>12/10/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Security Process</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Batonsville - Balto. Co. Md</i>	
24. FUNERAL DIRECTOR NAME <i>Walter + Sons Funeral Home Inc.</i>		ADDRESS <i>2501 Pennsylvania</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Cairns</i>	

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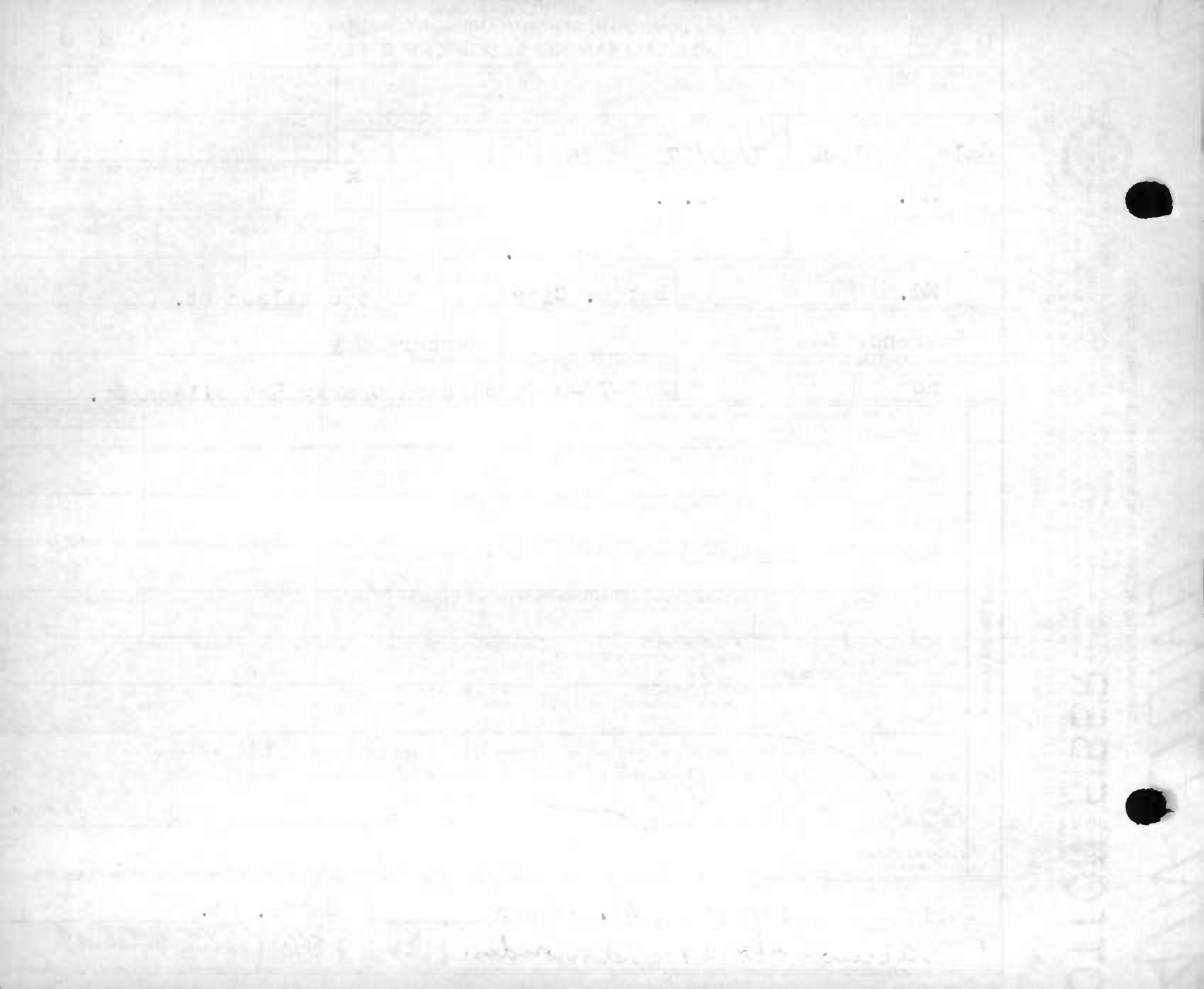
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
TO FUNERAL DIRECTOR: PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR THE MEDICAL EXAMINER. PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826

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1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 6 2 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Lawrence Lee										2a. DATE KNOWN OF DEATH ESTIMATED 12 27 83		2b. HOUR 12:20					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7/29/57		6. AGE (IN YEARS) LAST BIRTHDAY 26 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 27 83		2d. HOUR 12:20					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Balto. City		13c. CITY OR TOWN Balto. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 566 Wilson St. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Lee										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Day							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 213-70-0245				17. INFORMANT Barbara Conway				ADDRESS 566 Wilson St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder 7803 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 12/27/83					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.							
24. FUNERAL DIRECTOR NAME Wainwright				ADDRESS 2700 Edmondson				25a. DATE REC'D. BY REGISTRAR DEC 29 1983				25b. REGISTRAR'S SIGNATURE John J. Connel					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEFTER LAURENCE LEE			2a. DATE OF DEATH MONTH DAY YEAR 12 17 83			2b. HOUR 7:55A M					
1. SEX Male		4. RACE Black		5. DATE OF BIRTH July 10 th 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kilmarnock, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Oil Co.	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 717 Druid Park Lake Drive		13f. APT. NO. Apt. 601	
14. FATHER'S NAME FIRST MIDDLE LAST Richard H. Lee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ione Hill				ADDRESS 803 Old County Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Ione W. Williams		ADDRESS Severna Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac + respiratory arrest</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a. <u>Lung cancer</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DECEMBER 5</u> , 19 <u>83</u> , to <u>DECEMBER 17</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 17</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (a) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>Kathleen M. Fanning MD</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/18/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kathleen M. Fanning</u>						22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO., MD. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY Balto. National Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Nutter & Sons 2501 Gwynns Falls Pkwy Funeral Home Inc. Baltimore, Maryland 21216						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Patrick J. Lee		12 7 83 6:36 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	6 27 61	22 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Baltimore, City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore	St. Agnes Hospital		Fork Life Oper.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE	12b. KIND OF BUSINESS OR INDUSTRY
Maryland	Baltimore	2207 Gaylawn Drive 21227	Churchill Dist.
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
Francis Lee	Doris Hutchins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217-76-9211	Janet P. Lee	2207 Gaylawn Drive 21227
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dilated Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Viral Etiology</u> VIRUS INFECTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 24, 1983</u> to <u>December 19, 83</u> , that (I) (we) last saw the deceased alive on <u>October 19, 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<u>Stephen J. Plantholt</u>	MD		12/7/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Stephen J. Plantholt, M.D.	3455 Wilkens Ave. Balto. #21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/12/83	New Cathedral Cem.	Baltimore Maryland
24. FUNERAL DIRECTOR	NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hubbard Funeral Home, Inc.	4107 Wilkens Ave. 21229	DEC 9 1983	<u>John J. Carver</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROBERT J. LEE					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1983			2b. HOUR 10:44pm			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 26 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 1108 Rutland Avenue 21213					
14. FATHER'S NAME FIRST MIDDLE LAST John Lee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Edwards						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. 243-20-2913		17. INFORMANT ADDRESS Lillie B. Lee 1108 Rutland Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Ventricular Tachycardia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 83 , to 12/3 , 19 83 , that (I) (we) last saw the deceased alive on 12/3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. A. Runge					DEGREE MD			22c. DATE SIGNED 12/3/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUNGE					22e. ADDRESS Johns Hopkins Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ayden, N.C.				
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Caserio				

RECEIVED
FEB 10 1964
U.S. DEPT. OF JUSTICE

TO: SAC, NEW YORK
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Willie Lee		MONTH DAY YEAR 12 30 83	
3. SEX		2b. HOUR	
Male		M	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
Black		77 YRS	
5. DATE OF BIRTH		IF UNDER 1 YEAR	
MONTH DAY YEAR 11 08 06		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Va.		USA	
10. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto.		Baltimore City MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
2012 N. Washington St.			
12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY	
Md.		Balto.	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Hartwell Lee		FIRST MIDDLE LAST Daisy Gee	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
No		213-07-0392	
17. INFORMANT		ADDRESS	
Frankie Lee		2305 Monticello Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cardiac arrest		12/30/83	
4960 DUE TO, OR AS A CONSEQUENCE OF			
(b) Arrhythmia		12/30/83	
DUE TO, OR AS A CONSEQUENCE OF			
(c) COPD		?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
Thickened mitral valve.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHEEL <input type="checkbox"/> NOT WHEEL <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 07/29/81 , 19 81 , to 12/30 , 19 83 , that (I/we) lost the deceased alive on 12/07 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Gregory Kelly MD		Dec 30, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Gregory Kelly MD		1000 E. Eager St. 21202	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		1/3/84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Unity Bapt Ch Cem.		Kenbridge, Va.	
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY REGISTRAR	
NAME ADDRESS Wm C March F/H, Inc 1101 E. North Ave		DEC 30 1983	
		25b. REGISTRAR'S SIGNATURE	
		John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Arthur Christ LEFTERIS						2a. DATE OF DEATH MONTH DAY YEAR 11 25 83		2b. HOUR 9:55 AM	
3. SEX M		4. RACE Sauc.		5. DATE OF BIRTH MONTH DAY YEAR 01 09 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Trikkala, Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Singi Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Food Market	
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 96 Bond St 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Christ L. Lefteris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pagona Amprazis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 11 215 18 2958		17. INFORMANT ADDRESS Tula Fekas Lefteris (same as above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4414 IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Multiple organ failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Sens's Liver disease									
19a. DATE OF OPERATION 11/23/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED infected aortic graft, splenomegaly				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 83 , to 11/25 , 19 83 , that (I) (we) lost saw the deceased alive on 11/25/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ira Blecker				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA BLECKER				22e. ADDRESS Singi Hospital of Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-28-83		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens Finksburg Carroll Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Paul Fletcher		24b. ADDRESS 254 East Main St. Westminster, Md. 21157		25. DATE REC'D. BY REGISTRAR NOV 30 1983		25b. REGISTRAR'S SIGNATURE Paul J. Carver			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FRANK RICHARD LEIBIG				2a. DATE OF DEATH MONTH DAY YEAR DEC. 1 1983		2b. HOUR 2:45 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 1 19 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Union Comp.	
13a. STATE MARYLAND		13b. COUNTY =====		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Frank MIDDLE R. LAST Leibig		15. MOTHER'S MAIDEN NAME FIRST Augusta MIDDLE LAST Haun		13e. STREET ADDRESS 1024 Stoll Place 21225			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 216-07-9053		17. INFORMANT ADDRESS Gladys M. Leibig Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5325 IMMEDIATE CAUSE (a) RESPIRATORY ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC OBSTRUCTIVE LUNG DISEASE						YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) perforation of duodenal ulcer							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION CONGESTIVE HEART FAILURE							
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA NA NA NA			
22a. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 83 , to 12/1 , 19 83 , that (I) (we) lost saw the deceased alive on 11/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Fluorante Richard Mawcau				DEGREE MD		22c. DATE SIGNED 12/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MAWCAU				22e. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Balto.		23d. LOCATION CITY OR TOWN COUNTY STATE A.A. Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy, Balto				25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Conish	

BP

George A. Gorse 4001 Ritchie Hwy, Baltimore

Serial

12/4/55

John Hill Cemetery, Baltimore

Vol. 10



PO BOX 1000
BALTIMORE, MD 21201

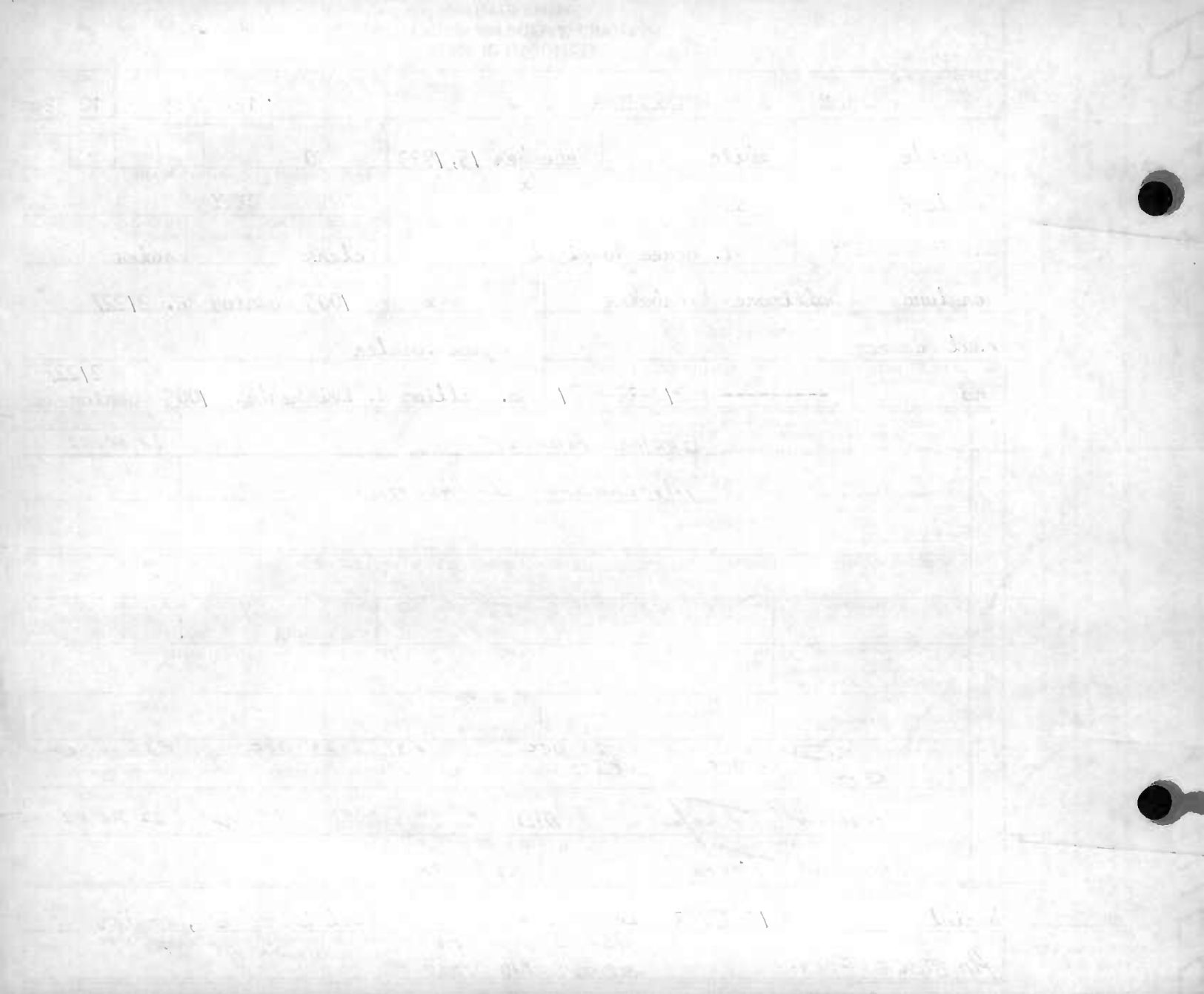
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HELEN M LEIMKUHLER				2a. DATE OF DEATH MONTH DAY YEAR 12/22/83		2b. HOUR 12:52 PM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR December 15, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY sales	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland	13c. COUNTY Baltimore	13d. CITY OR TOWN Arbutus	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13f. STREET ADDRESS / ZIP CODE 1005 Downton Rd. 21227		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Adamecz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Fossler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-32-6771		17. INFORMANT ADDRESS Mr. William R. Leimkuhler 1005 Downton Rd 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>CARAC ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 HOURS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u>						
(c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>21 DEC</u> , 19 <u>83</u> , to <u>22 DEC</u> , 19 <u>83</u> , that (I) <u>did</u> did not saw the deceased alive on <u>22 DEC</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> did not view the body after death.						
22b. SIGNATURE Andrew Trofa		DEGREE MD		22c. DATE SIGNED 22 DEC 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Trofa		22e. ADDRESS 900 CATON				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 25 1983				
24. FUNERAL DIRECTOR NAME AMBROSE F. H.		ADDRESS 1328 Sulphur Spr. ARBUTUS MD 21227				



IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		7b. HOUR		7c. MIN.					
EDWIN				THOMAS		LEONARD		12-12-83								2:00		A.M.					
3. SEX		MALE		4. RACE		WHITE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE		(IN YEARS LAST BIRTHDAY)					
								2		14		03		80		YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Maryland		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
								Baltimore City MD.															
10. CITY OR TOWN OF DEATH		Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Stock Clerk		12b. KIND OF BUSINESS OR INDUSTRY		Clothing Bus									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE													
Maryland						Baltimore		YES		1718 Ramsay Street 21223													
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST									
Harry		F.				Leonard		Emma						Stivers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		216-03-2398		17. INFORMANT		ADDRESS													
								Ruth I. Brandley		1718 Ramsay St.		21223											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS PERITONEI 1570 DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF HEAD OF PANCREAS - JUNE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - DAYS																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 12-12-83, to 12-12-83, that (I) (we) last saw the deceased alive on 12-12-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>[Signature]</i>																DEGREE <i>[Signature]</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/12/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vasquez P. Rodriguez MD																22e. ADDRESS 1940 W. Balt St BROD MD 21223							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		Burial		23b. DATE		12/15/83		23c. NAME OF CEMETERY OR CREMATORY		Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE		Baltimore Maryland									
24. FUNERAL DIRECTOR NAME		Hubbard Funeral Home, Inc.		ADDRESS		4107 Wilkens Ave.		25. DATE RECEIVED BY REGISTRAR		DEC 14 1983		25b. REGISTRAR'S SIGNATURE		<i>[Signature]</i>									

Handwritten notes and signatures, including a large signature at the bottom left and various scribbles and markings throughout the page.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Homer Melville Lester.			2a. DATE OF DEATH MONTH DAY YEAR 12 5 83			2b. HOUR 4:25 M			
3. SEX M		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 9 12 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rockford Ill.		7b. CITIZEN OF WHAT COUNTRY? yes		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4403 Liberty Heights Ave	
14. FATHER'S NAME FIRST MIDDLE LAST William Turner Lester			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Herbert William Sands			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes			
16b. SOCIAL SECURITY NO. 118-01-8755			17. INFORMANT Franklin D. Lester			ADDRESS P.O. B-58 Pulteney			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiomyopathy arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis ARDS + DIC.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute pneumonia.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>small bowel obstruction + peritonitis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>83</u> , to <u>12-5</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jose R. Alvarado						DEGREE MD		22c. DATE SIGNED 12-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose R. Alvarado MD						22e. ADDRESS Sinai Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-7-83		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME Barclay H. H. 1348 Calverton Rd			25a. DATE REC'D. BY REGISTRAR DEC 7 1983			25b. REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 6 3 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL H. LEUTBECHER		2a. DATE OF DEATH MONTH DAY YEAR 12/22/83		2b. HOUR MIN 5:20 A M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE UNION MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nursing		12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY -		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse S. Hine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Emma De Grange		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 30 2185		17. INFORMANT ADDRESS Robert E. Leutbecher 1014 E. Lake Ave. 21212	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2080 IMMEDIATE CAUSE (a) acute leukemia
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 22, 19 83, to December 22, 19 83, that (I) (we) last saw the deceased alive on December 22, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Victoria A. Vanik		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTORIA A. VANIK, M.D.		22e. ADDRESS THE UNION MEMORIAL HOSPITAL					

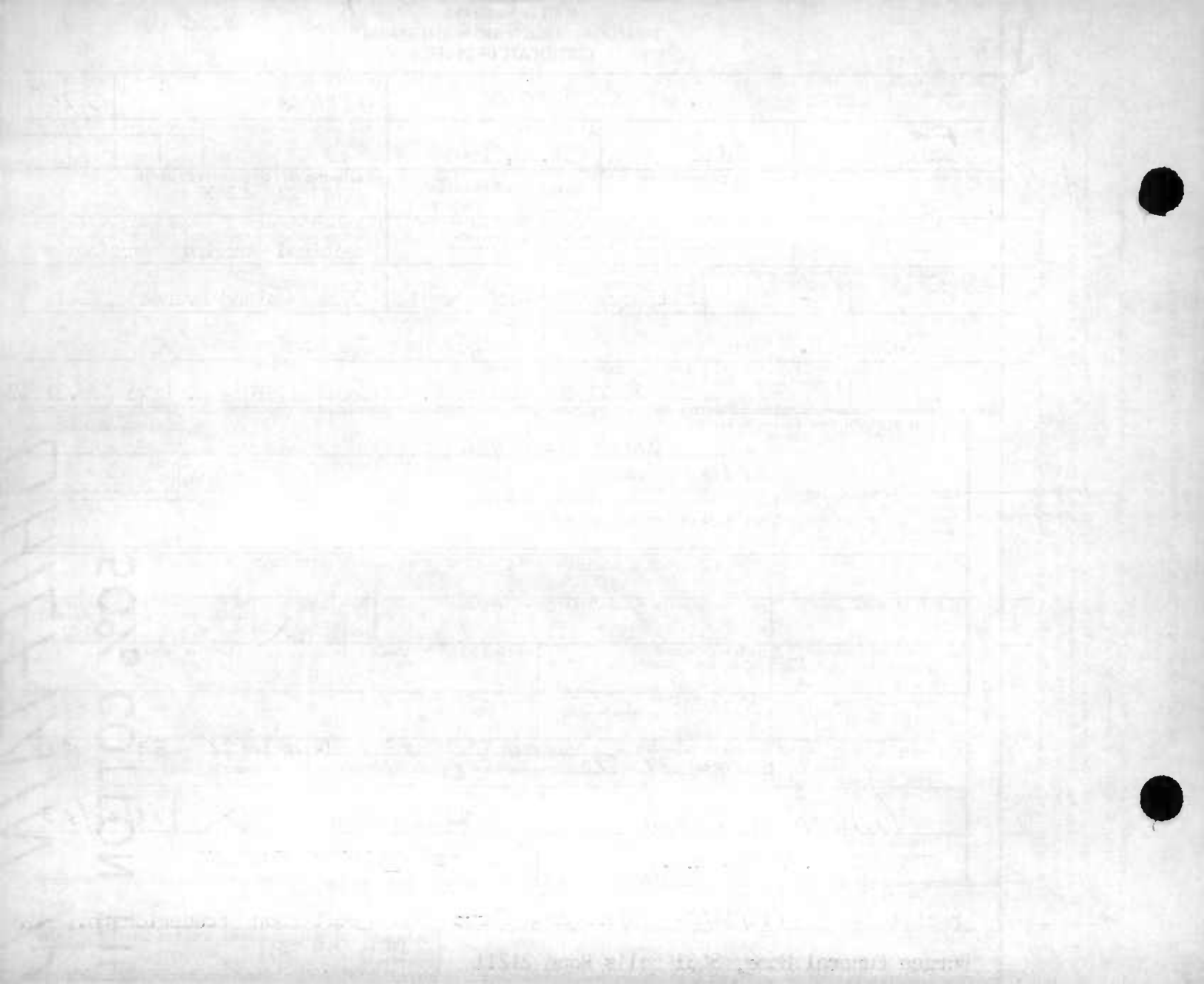
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY Jefferson Church Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Co., Md.	
--	--	-----------------------	--	--	--	--	--

24. FUNERAL DIRECTOR NAME Burgee Funeral Home, 3631 Falls Road 21211		25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) EMILY E. LEWIS						MONTH 12 DAY 30 YEAR 83				2b. HOUR 27 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July DAY 29 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Bakery			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MA ryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1100 Bolton Street 21201	
14. FATHER'S NAME FIRST Sherman MIDDLE Leander LAST Niven						15. MOTHER'S MAIDEN NAME FIRST Mary Ann MIDDLE Flynn LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Earl H. Lewis		ADDRESS 1406 Glenwilde 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 3 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic Heart Disease - Congestive Heart Failure; Right & Left; Multiple Sclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/4/81 to 12/30/83 , that (I) (we) last saw the deceased alive on 12/8/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Albert B. Bradley				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert B. Bradley				22e. ADDRESS 4900 Belair Road							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-3-83		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Co., Md			
24. FUNERAL DIRECTOR NAME Burgee aFuneral Home, Baltimore, Maryland ADDRESS 						25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. [Signature]			

BP

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Little Remembrance 34.

Alcornoque de la India = Cuscuta flava, Cuscuta indica.

15/3/57

12/12/88

15/12/51

1/3/84

62

Mr. & Mrs.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32641	
1. DECEASED NAME (TYPE OR PRINT) ROSA A. LEWIS		2. DATE OF DEATH MONTH 12 DAY 17 YEAR 1983		2b. HOUR 12 17 83	
3. SEX FEMALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH NOV. DAY 24 YEAR 1912	6. AGE (IN YEARS LAST BIRTHDAY) 71 YES	7. UNDER 1 YEAR MONTHS 12 DAYS 17 HOURS 17 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION BALTIMORE CITY HOSPITALS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAL SERV	12b. KIND OF BUSINESS OR INDUSTRY GSA	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. COUNTY BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 4725 OLD YORK RD 21212	
14. FATHER'S NAME FIRST PETER MIDDLE DICKENS LAST DICKENS		15. MOTHER'S MAIDEN NAME FIRST DORA MIDDLE HARRISON LAST HARRISON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 579-26-6593		16c. ADDRESS WINZELL JENKINS/4020 1st St. SE WASH MOSES DICKENS/4107 CALLOWAY AV 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: adult onset diabetes mellitus; Demencia; probable alzheimer's type					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 82 , to Dec 17 , 19 83 , that (I/we) last saw the deceased alive on Dec 16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John J. Lewis		DEGREE		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kittner, Steven J		22e. ADDRESS Baltimore City Hospitals Eastern Ave, Balt. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/22/83	23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PK	23d. LOCATION CITY OR TOWN BALTIMORE COUNTY BALTO STATE MD.	
24. FUNERAL DIRECTOR NAME MARSHALL W. JONES, JR. ADDRESS 4101 EDMONDSON AVE., BALTIMORE, Md.			25a. DATE REC'D. BY REGISTRAR DEC 22 1983	25b. REGISTRAR'S SIGNATURE John J. Lewis	



IT IS THE POLICY OF THE UNITED STATES GOVERNMENT
TO MAKE AVAILABLE TO THE PEOPLE OF THE UNITED STATES
AND TO THE PEOPLE OF OTHER COUNTRIES THE INFORMATION
AND KNOWLEDGE WHICH ARE NECESSARY FOR THE PROGRESS
OF SCIENCE AND ARTS AND FOR THE ENLIGHTENMENT
OF THE MINDS OF THE PEOPLE OF THE UNITED STATES
AND OF THE PEOPLE OF OTHER COUNTRIES
AND TO MAKE AVAILABLE TO THE PEOPLE OF THE UNITED STATES
AND TO THE PEOPLE OF OTHER COUNTRIES THE INFORMATION
AND KNOWLEDGE WHICH ARE NECESSARY FOR THE PROGRESS
OF SCIENCE AND ARTS AND FOR THE ENLIGHTENMENT
OF THE MINDS OF THE PEOPLE OF THE UNITED STATES
AND OF THE PEOPLE OF OTHER COUNTRIES



THE UNITED STATES GOVERNMENT
DEPARTMENT OF COMMERCE
BUREAU OF PATENTS
WASHINGTON, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EMILY		FIRST LEYKO		LAST		2a. DATE OF DEATH MONTH DAY YEAR 12-27-83				2b. HOUR 5:30 A.	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 17 22		6. AGE (IN YEARS LAST BIRTHDAY) 61				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3202 HUDSON ST. 21224				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3202 HUDSON ST. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST WALTER M. LEYKO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GAULIK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-10-7002		17. INFORMANT ADDRESS Lucille Behk SAME 21224							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 1519 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) did not attended the deceased from 8-21 , 19 67 , to 12-10 , 19 83 , that (I) xx lost saw the deceased alive on 12-10 , 19 83 , and that in (my xx) opinion death occurred on the date and hour and from the causes stated above, (I) xx (did not) view the body after death.			
22b. SIGNATURE Melito M. Torres		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 12-27-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melito M. Torres, M.D.		22e. ADDRESS 441 S. Ellwood Ave. Balto. Md. 21224	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 12-30-83		23c. NAME OF CEMETERY OR CREMATORY ST-STANISLAUS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS J. SKARDA 2829 HUDSON ST.				25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

NOTICE

NOTICE

EX-101-01-

EX-101-01-

EX-101-01-01

EX-101-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed in the hospital after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EVA					FIRST LIEBMAN					2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 83		2b. HOUR 5:42 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 2 DAY 21 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. XX		IF UNDER 1 YEAR MONTHS XX DAYS XX		IF UNDER 24 HRS HOURS XX MIN. XX			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3501 FALLSTAFF RD. 21215					
14. FATHER'S NAME FIRST BENJAMIN MIDDLE MINHOFF LAST ADAMS					15. MOTHER'S MAIDEN NAME FIRST FANNIE MIDDLE ADAMS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-36-4238		17. INFORMANT ADDRESS MR. LEONARD LIEBMAN 3501 FALLSTAFF RD. BALTO., MD 21215									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF Congestive heart failure 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Anterior Septal myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 17 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION 11/27		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ANNUAL				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that the (this hospital) attended the deceased from 11/27 , 19 83 , to 12/13 , 19 83 , that (I was) lost saw the deceased alive on 12/12 , 19 83 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I was) (did) (did not) view the body after death.													
22b. SIGNATURE RM Cooper MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 12/13/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Cooper MD					22e. ADDRESS Sinai Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 15, 1983		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION REISTERSTOWN BALTO. MD							
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. L...					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) IDA R LINDSAY		2a. DATE OF DEATH MONTH DAY YEAR 12/31/83	
3. SEX Female		2b. HOUR 2:58 A.M.	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 7 2 09		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) THE UNION MEMORIAL HOSPITAL 21218	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Balto. City Poli	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Robinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisey M. Standiford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-8420	
17. INFORMANT ADDRESS Pat Morgan 4401 Buchanan Ave. 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory/Cardiac arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemiparesis of brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>extensive right middle cerebral artery stroke</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> 19 <u>83</u> , to <u>12/31</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Robert S. Tano MD</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED 12/31/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. TANO MD		22e. ADDRESS 201 E. UNIVERSITY PKWY.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/84	
23c. NAME OF CEMETERY OR CREMATORY Middletown Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Freeland Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211		25a. DATE REC'D. BY REGISTRAR JAN 5 1984	
25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BENJAMIN LIPNICK			2a. DATE OF DEATH MONTH DAY YEAR DEC. 1ST 1983			2b. HOUR 12:35 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 27 1886		6. AGE (IN YEARS LAST BIRTHDAY) 97	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDAVE HEBREW GERIATRIC CENTER + HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	
12b. KIND OF BUSINESS OR INDUSTRY RETAIL		13a. STREET ADDRESS 2500 W. BELVEDERE AVE					
13b. STATE MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS CONCORD APTS. 212N	
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS LIPNICK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLICKA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-10-3255		17. INFORMANT MRS. ESTELADE NEWMAN APT. 12 2907 FALLSTAFF RD. BALTO., MD 21208			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5070 IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)
DUE TO, OR AS A CONSEQUENCE OF		(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 11/30 19 83 , to 12/1 19 83 , that (s/he) lost saw the deceased alive on 12/1 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s/he) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Estrelita O. Ku				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KU				22e. ADDRESS LEVINDAVE HEBREW GERIATRIC CENTER + HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 2, 1983		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND	
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24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leon John Litaker			2a. DATE OF DEATH MONTH DAY YEAR 12-10-83		2b. HOUR 11:20AM
3 SEX male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8-13-02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) at Fertilizer Co		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John (Hayes) H. Litaker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie S. (Thomson) Torrance		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-01-0004		17. INFORMANT Keith Litaker	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5850 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (c) End Stage Kidney disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-9 , 19 83 , to 12-10 , 19 83 , that (I) (we) last saw the deceased alive on 12-10 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rhonda Richards, MD		DEGREE MD		22c. DATE SIGNED 12-10-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Shabazz		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/15/83		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co, Md.		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 12 1983 John J. Connel			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 3 3 2 6 4 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN H. LITTLETON			2a. DATE OF DEATH MONTH 12 DAY 6 YEAR 83		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 9 DAY 29 YEAR 97		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6013 Clearspring Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6013 Clearspring Road 21212
14. FATHER'S NAME FIRST George MIDDLE LAST Harrison		15. MOTHER'S MAIDEN NAME FIRST Anniebelle MIDDLE LAST Houston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216-46-0761		17. INFORMANT Ms. Kathleen Littleton (Same as #13.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Parkinson's disease, Osteoarthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/1/83 to 11/25/83 , that (I) lost saw the deceased alive on 12/1/83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I have) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN -M. TUN		22e. ADDRESS 8400 Lochraven Blvd Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECEIVED BY REGISTRAR DEC 15 1983			
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.		24b. DATE RECEIVED BY REGISTRAR DEC 15 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Goldie		Lloyd		12		21		83	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. BALTIMORE CITY OR COUNTY OF DEATH	
Female		Cauc		MONTH DAY YEAR 12 13 09		74 YRS.		BALTIMORE CITY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
MARYLAND		US				BALTIMORE CITY		BALTIMORE MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
SINAI HOSPITAL		HOUSEWIFE		AT HOME		3919 SINCLAIR LANE		BALTO., MD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
JACOB		RACHAEL		NO		220-12-6609		MRS. MARLENE PRINCE APT. T-2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5522 DUE TO, OR AS A CONSEQUENCE OF (b) PUL EMBOLI OR Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)		12-01-83		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Nov 30, 19 83, to Dec 21, 19 83, that (I) (we) last saw the deceased alive on Dec 21, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
GARY HAMAMOTO		12/21/83		GARY HAMAMOTO		SINAI		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
12/23/83		MIKRO KODESH-BETH ISRAEL		BALTIMORE		SOL LEVINSON & BROS., INC.		DEC 29 1983	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS		25d. CITY OR TOWN		25e. STATE		25f. ZIP CODE	
John J. Smith		BALTO., MD.		21215		21215		21215	



CHIEF MAN

20% COTTON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Willie L. Lloyd		2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR 12 3 19 83		2b. HOUR M 2:52P
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 11 34	6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 0 0 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,		MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 N. Washington Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joe Lloyd		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-32-1826		17. INFORMANT ADDRESS Will Lloyd 6212 Nahhant Road
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes with complications 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Thomas D. Smith, M.D.		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 12/4/83
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St.		CITY Balto., MD.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/10/83	23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR DEC 8 1983
				25b. REGISTRAR'S SIGNATURE John J. Carver



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept and returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and the medical certificate must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 6 5 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT PUTMAN LOGAN SR.					2a. DATE OF DEATH MONTH DAY YEAR 12 5 83		2b. HOUR 9:25 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MARYLAND 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Standard Oil			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Eastpoint		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7223 Bridgewood Dr. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Logan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Baer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES-NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 161 18 7873		17. INFORMANT ADDRESS Charlotte Jean Nicholson, Daughter Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Respiratory Distress</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Cell Ca Lung i prob Bronchitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 w 2 d	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 28, 1983</u> to <u>DECEMBER 5, 1983</u> , that <input checked="" type="checkbox"/> (we) lost <u>saw the deceased alive on</u> <u>DECEMBER 5, 1983</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>U. Brundt MD</u>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>U. Brundt</u>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Brundzinski Funeral Home</u>					25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

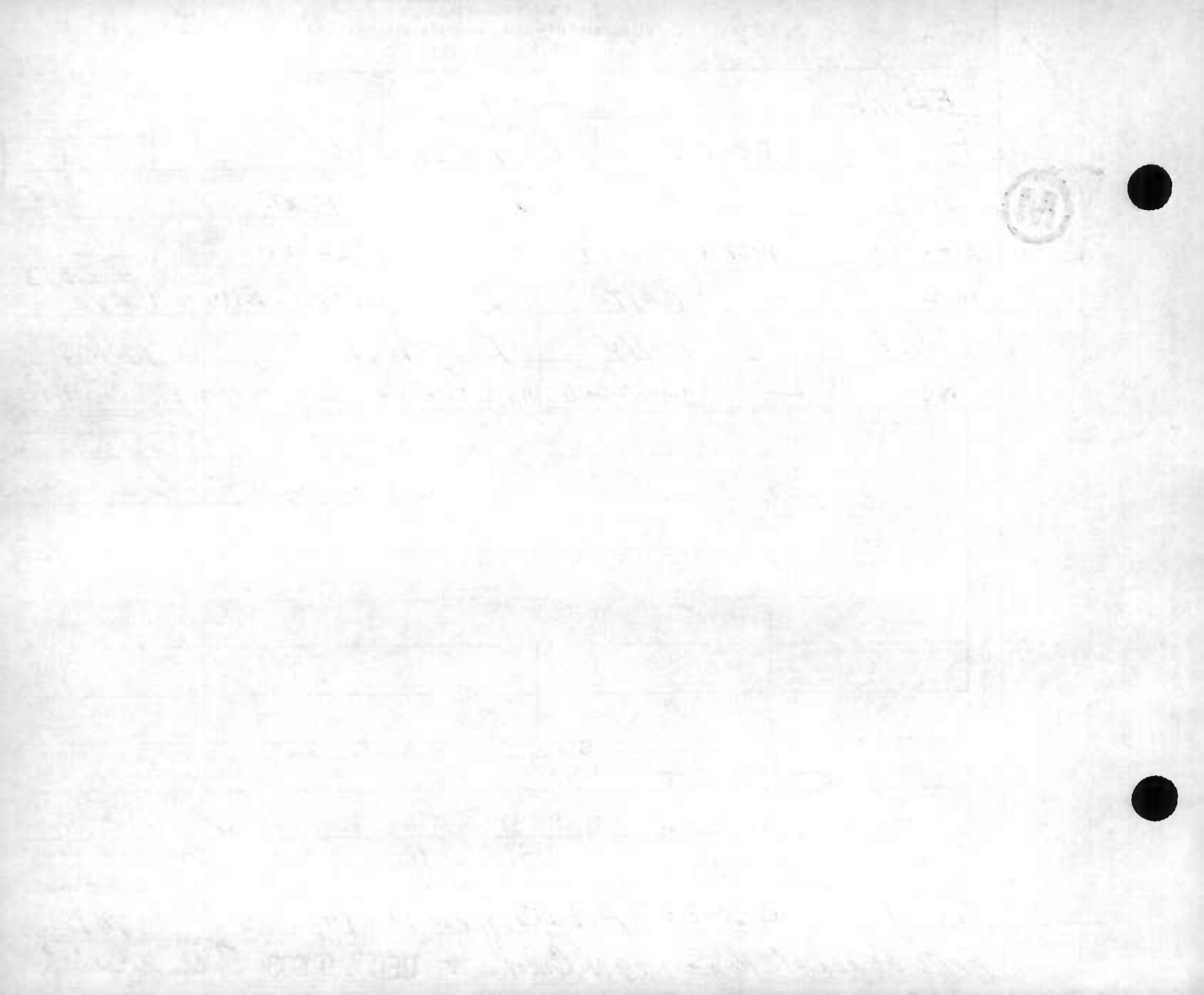
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Long		2a. DATE OF DEATH MONTH DAY YEAR 12-15-83		2b. HOUR M
3. SEX F	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 5-1-17		6. AGE (IN YEARS LAST BIRTHDAY) 66
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT.
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1428 N. Ellwood Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D.		13b. COUNTY —	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME (TYPE OR PRINT) Caleb		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Elizabeth Miles		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-30-6410		17. INFORMANT ADDRESS Miss Bertha Long 1428 N. Ellwood Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 7100 DUE TO, OR AS A CONSEQUENCE OF (b) systemic lupus erythematosus DUE TO, OR AS A CONSEQUENCE OF (c) many (>10) years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from July 19 82, to June 19 83, that (I) (we) last saw the deceased alive on July 22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Patricia A Tewes MD PhD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia A Tewes		22e. ADDRESS Baltimore MD Dept of Medicine, Johns Hopkins Hosp		
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 12-20-83	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus M.D.
24. FUNERAL DIRECTOR NAME Betts Funeral Home		ADDRESS 1129 N. Caroline St		25a. DATE REC'D. BY REGISTRAR DEC 19 1983
		25b. REGISTRAR'S SIGNATURE John J. Gough		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by medical examiner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR FRANK H. LORD							
1. DECEASED NAME (TYPE OR PRINT) FRANK H. LORD				2a. DATE OF DEATH MONTH 12 DAY 27 YEAR 83		2b. HOUR 3:35 AM	
1. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 05 DAY 03 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MOLD MAKER		12b. KIND OF BUSINESS OR INDUSTRY WHEATON INDU	
13a. STATE NEW JERSEY		13b. CITY OR TOWN MILLVILLE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 908 WOOLAND 08332	
14. FATHER'S NAME FIRST FRANK MIDDLE H. LAST LORD		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE MURPHY LAST MURPHY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 1143221610		17. INFORMANT ADDRESS MILLVILLE N.J. BARBETTI FUNERAL HOME 2104 E. MAIN ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Premature repticemia							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of the colon.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-21- 19 83 , to 12-27 19 83 , that (I) (we) lost saw the deceased alive on 12-27 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Sergio Cassanego MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Sergio Cassanego				22e. ADDRESS 5601 LOCH RAVEN BLVD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY ENGLENTON CEMETERY		23d. LOCATION CITY OR TOWN CLARKSBORO COUNTY - STATE Conn	
24. FUNERAL DIRECTOR John Wool				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. SIGNATURE John Wool	

20% COTTON

11/11/54



Handwritten notes and text, mostly illegible due to fading and bleed-through. Some visible words include "RECEIVED", "NOV 11 1954", "11/11/54", "20% COTTON", and "11/11/54".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)FIRST
WILLIAMMIDDLE
J.LAST
LOVETT

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

12 22 / 83

3 25 AM

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

8 8 1917

6. AGE - (IN YEARS LAST BIRTHDAY)

66

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS

DAYS

HOURS

MIN.

7a. BIRTHPLACE
(COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

UNION MEMORIAL HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR

INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3446 Chestnut Ave. 21211

14. FATHER'S NAME

FIRST

MIDDLE

LAST

William

J

Lovett

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Mary

Ellen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215-05-3759

17. INFORMANT

ADDRESS

Christine Gorsuch 5527 Mattfeldt Ave. 21209

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Esophageal Cancer

1509

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pneumonia

19a. DATE OF OPERATION

11/23/83

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Feeding gastrostomy for Esophageal Ca

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

N/A

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/4/83, 19, to 12/22/83, 19, that (I) (we) lost

saw the deceased alive on 12/22/83, 19,

above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

Paul Miller

DEGREE

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☒

22c. DATE SIGNED

12/22/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

PAUL MILLER M.D.

22e. ADDRESS

UNION MEMORIAL HOSPITAL

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/24/83

23c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

23d. LOCATION

Baltimore

COUNTY

Md. STATE

24. FUNERAL DIRECTOR

NAME

A. Alan Seitz, Jr. 3818 Roland Ave. Balto 21211

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 29 1983 John J. Gierach

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• • •

bra[ya]

grouped in

 Springer

THIS DOCUMENT CONTAINS

1997

John

then

215-06-3750 Christian Avenue 2227 Westfield Ave. 2122

Letter

13/15/51

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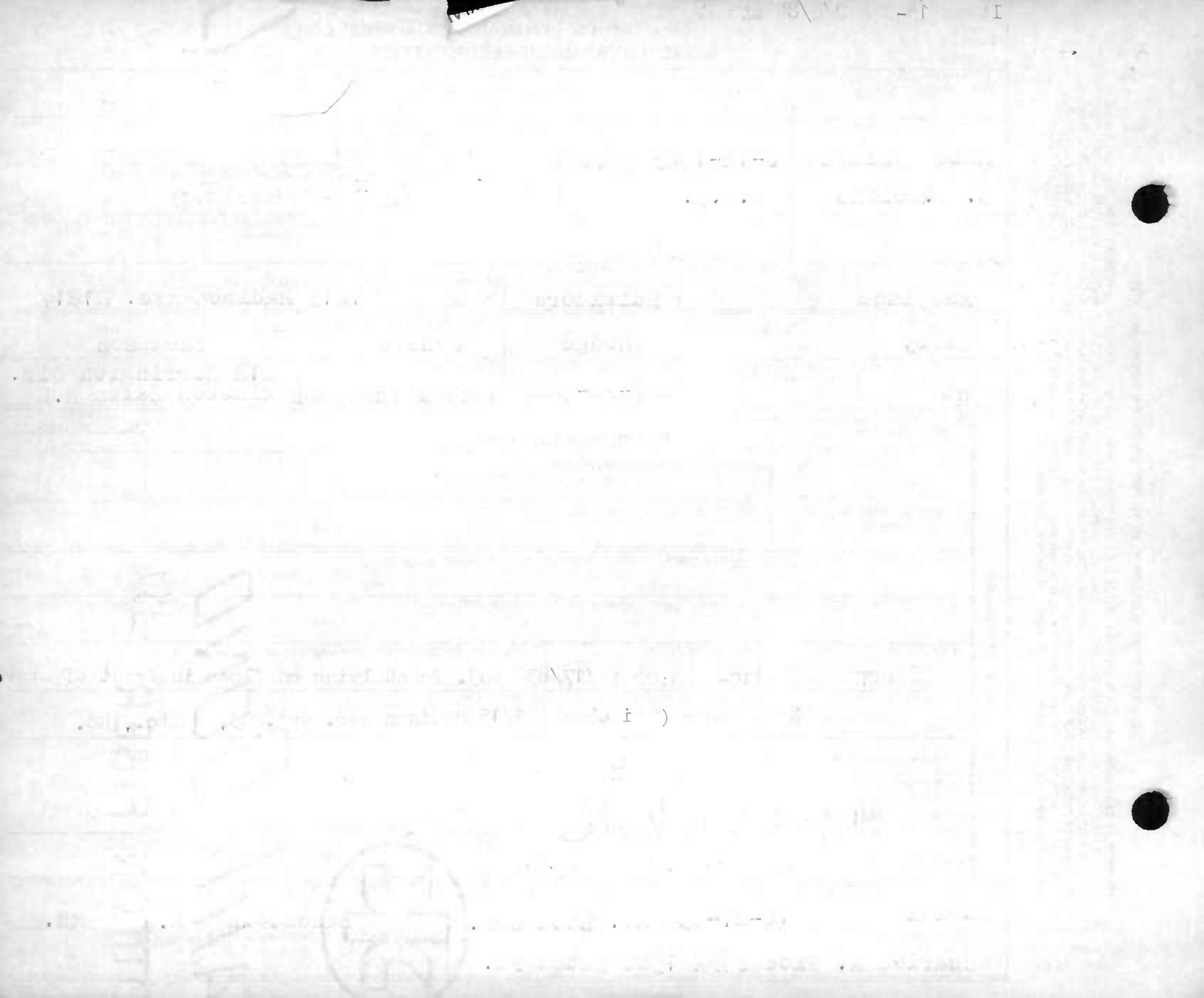
11-11-68

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME FIRST MIDDLE LAST CALVIN LUCKY									
2a. DATE KNOWN OF DEATH		xx MONTH DAY YEAR		2b. HOUR		2c. DATE PRONOUNCED DEAD			
12-17-83		12-17-83		1:02pm					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. IF UNDER 24 HRS.	
Male		Black		8-12-1943		40 YRS.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH					
S. Carolina		U.S.A.		Baltimore City					
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
1215 Madison Avenue									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland				Baltimore				1215 Madison Ave. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Leroy Hodge				Geneva Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				247-72-4207		Geneva Thompson Winston Salem N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STOTING THE UNDERLYING CAUSE LOST.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				10- P.M. 1:02 12/17/83		subj. found lying on floor in front of stove			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)		21f. LOCATION			
				home (kitchen)		1215 Madison ave. apt. 203, Balto., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-18-83	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
12-21-83				Mt. Zion Cem.		Landsdown		A.A. Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles A. Rice FSPA				1300 Eutaw Pl.		JAN 3 1984		<u>John J. Coniff</u>	

DHMH - 17
(VR A15 ME (5))
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 32655	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN CARROLL LUNN						2a. DATE OF DEATH MONTH DAY YEAR 12-14-83		2b. HOUR 2 M			
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 7 1 32		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 531 W. 27th St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAVERN OWNER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY		13c. CITY OR TOWN BALTO			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN LUNN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADLINE BOWEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 248-364677		17. INFORMANT ADDRESS ROSE L LUNN 531 W 27th St							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov 10-17 83 , 19 80 , to 14 Dec 83 , 19 83 , that (I) (we) last saw the deceased alive on 10-17 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12/14/83	
22b. SIGNATURE H.W. D. HOLMES, M.D.				22e. ADDRESS 8019 PHILADELPHIA ROAD BALTO., MD. 21237				22f. DATE SIGNED 12/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.W. D. HOLMES, M.D.				22e. ADDRESS 8019 PHILADELPHIA ROAD BALTO., MD. 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-17-83		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO.					
24. FUNERAL DIRECTOR Paul E. Schenck 345 Chestnut Ave Balto Md						25a. DATE REC'D. BY REGISTRAR DEC 15 1983					
25b. REGISTRAR'S SIGNATURE John J. Connel						25c. REGISTRAR'S SIGNATURE					

20% COTTON FIB

CHEF ALM



DEC 1 9 1938

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME FIRST MIDDLE LAST WADDELL LYNCH			1a. DATE OF DEATH MONTH DAY YEAR 12/27/83		2b. HOUR 4:30 PM						
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 27 26		6. AGE (IN YEARS, LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 57		IF UNDER 2 HRS. HOURS MIN. 57	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1800 Braddish 21216			
14. FATHER'S NAME FIRST MIDDLE LAST LESLIE LYNCH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA SILVER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 239-40-6512		17. INFORMANT ADDRESS Lucille Lynch 1800 Braddish Avenue					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIORESP ARREST**5570**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **BOWEL ISCHEMIA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 12/22/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Infarction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 12/27 , 19 83 , that (I) (we) last saw the deceased alive on 12/27/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Applebaum				DEGREE MD		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rosier Applebaum				22e. ADDRESS University Hospital			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 1/2/84		23c. NAME OF CEMETERY OR CREMATORY Plumblin Holiness Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Enfield, N.C.	

24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. L... ..	
--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nora B. Lyons					2. DATE OF DEATH MONTH DAY YEAR 76 HOUR 12/ 28/ 83 11:51A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 92		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Jenkins Memorial, 1000 S. Caton Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bagley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wahan		13e. STREET ADDRESS 1000 S. Caton Ave. 21229					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-50-7518		17. INFORMANT Daughter Helen L. Ebaugh		ADDRESS 2804 Newton Street Wheaton, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that he (this hospital) attended the deceased from 6/29/ 19 83 , to 12/28/83 19 --- , that he (we) last saw the deceased alive on 12/27/ 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence R. Gallagher, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/28/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence R. Gallagher, M.D.				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, 1983		23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Glen, Maryland			
24. FUNERAL DIRECTOR NAME James C. DeVol				ADDRESS Washington, D.C.		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE James C. DeVol	

BP

B.

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White

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death has been reported to the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after a death has been reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32658	
1. DECEASED NAME (TYPE OR PRINT) Susan S Lytle				2a. DATE OF DEATH MONTH DAY YEAR 12/15/83	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7/28/43	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS. MONTHS 1 DAYS 1	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hosp		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		13. STREET ADDRESS / ZIP CODE 161 Cardman Drive 21037	
14. FATHER'S NAME FIRST MIDDLE LAST John Scheel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Onwig		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 219-50-2118		17. INFORMANT Donald H Lytle		ADDRESS 161 Cardman Dr Edgewater Md	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Hemorrhage & Shock DUE TO, OR AS A CONSEQUENCE OF (b) Brachial Artery Puncture and DUE TO, OR AS A CONSEQUENCE OF (c) Acute Leukemia Thrombocytopenia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 18 hrs. 13 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION 12/14/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Lip & Extremity Compartment Syndrome		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from Dec 8 , 19 83 , to Dec 15 , 19 83 , that (he) (she) (it) (we) lost above, (he) (we) (it) (we) did not view the body after death.					
22b. SIGNATURE Dennis J. Crangulio MD				22c. DATE SIGNED 12/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis J. Crangulio				22e. ADDRESS UMCC, Univ Maryland Hosp, Balt, Md.	
23a. BURIAL, CREMATION, REMOVAL (CHECK) Cremation		23b. DATE 12/15/83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood P.O. MD.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel ADDRESS ANNAPOLIS MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 16 1983 John J. Goring			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

32659

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. DATE KNOWN OF DEATH									
1 DECEASED NAME (TYPE OR PRINT)										2c. DATE KNOWN OF DEATH										2d. DATE KNOWN OF DEATH									
DOROTHY										MACK										12 9 19 83									
3 SEX										4 RACE										5 DATE OF BIRTH									
Female										White										8 13 13									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED									
Maryland										U.S.										NEVER MARRIED									
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION									
Baltimore										2535 N. Howard St.										Waitress									
13a. STATE										13b. COUNTY										13c. CITY OR TOWN									
Md.																				Balto.									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?									
William C. Meredith										Blanche Daniela Cox										No									
16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS									
213-01- 0513										Mrs. Betty Harry										5918 Plainfield Balto., Md. 21206									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																													
4292																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED									
										HOUR A.M. MONTH DAY YEAR										ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2									
21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										STREET, FACTORY, FARM, ETC.)										STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED									
										M.D. Assistant MEDICAL EXAMINER										12-11-83									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																			
Ann M. Dixon, M.D.										111 Penn St., Balto., Md. 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
Removal										12/14/83																			
24. FUNERAL DIRECTOR										25a. DATE REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
NAME										ADDRESS																			
Anatomy Board										Balto., Md.										DEC 16 1983									

OTTO L. A. B.
V. W. D. W. D.



Handwritten signature or name



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 32660

1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth - Macijeski</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>12 23 83</i>		2b. HOUR <i>7²⁰ PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>02 03 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Czechoslovakia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4320 Clareway Apt. 4 G 21213</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Francis - Pardubeky</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances -</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-18-1510</i>		17. INFORMANT ADDRESS <i>Mr. Joseph B. Macijeski</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> , 19 <i>83</i> , to <i>12/23</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/23</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Keith Kaufman</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>12/23/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KEITH D. KAUFMAN</i>				22e. ADDRESS <i>JOHNS HOPKINS HOSPITAL BALTIMORE, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 27, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Balto. Md/</i>			
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

MEDICAL CERTIFICATION

219

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Madison		2a. DATE OF DEATH MONTH DAY YEAR 12-10-83		2b. HOUR 4:10 PM
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR April 5, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Luthran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Vance Madison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McDuffie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. UNAVAILABLE		17. INFORMANT Celestine Johnson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Ventricular Tachycardia - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.H.F. Renal failure. DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 83 , to 12-10 , 19 83 , that (I) (we) last saw the deceased alive on 12-10 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE C. Shah		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. SHAH		22e. ADDRESS Leatheran Hospital BALTIMORE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried	23b. DATE 12-15-83	23c. NAME OF CEMETERY OR CREMATORY Int. Lutheran		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md
24. FUNERAL DIRECTOR NAME W.H. Bacon Funeral Home Inc.		25. DATE REC'D. BY REGISTRAR DEC 12 1983		26. REGISTRAR'S SIGNATURE [Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Western

Journal



WHEELER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

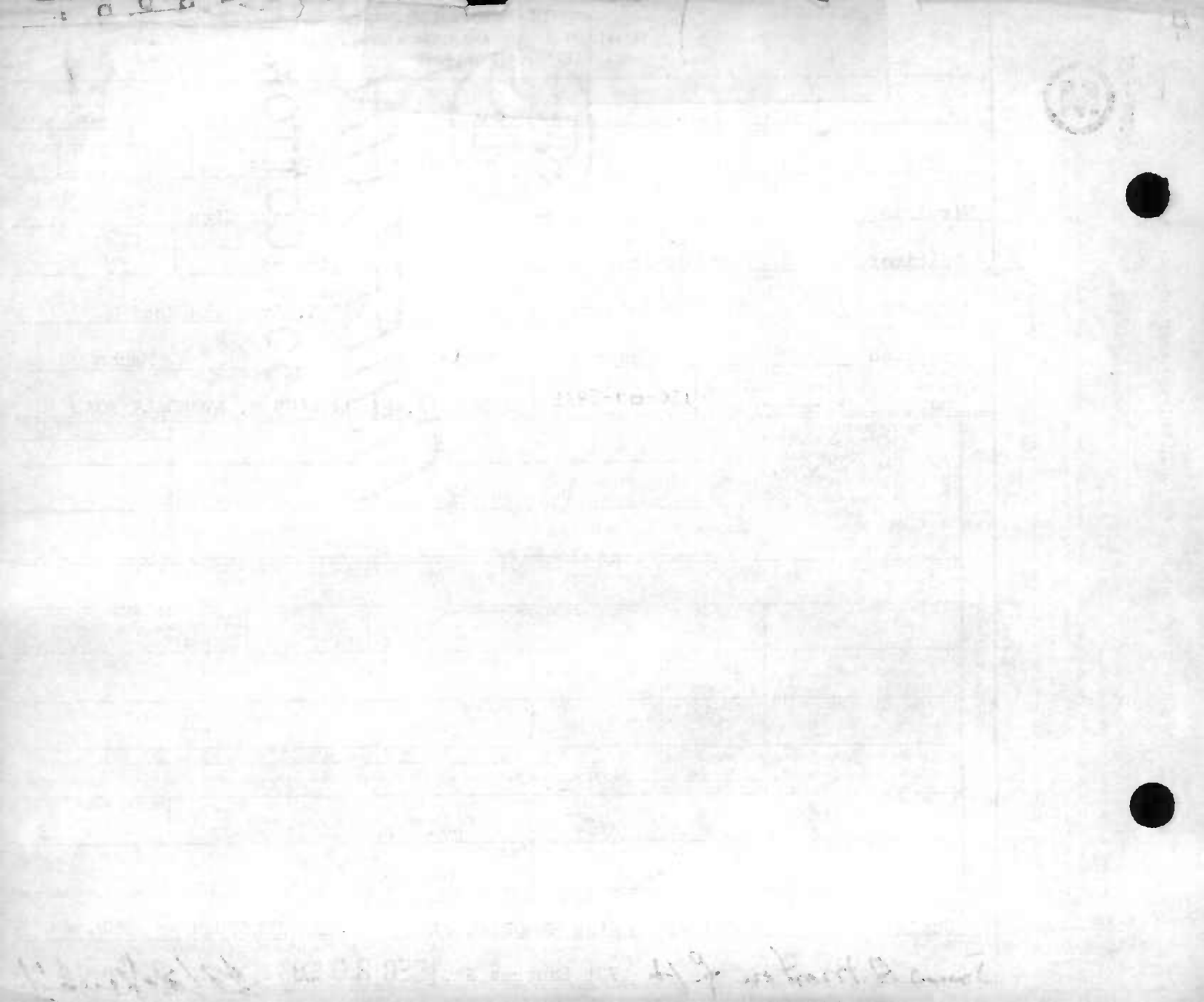
DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3266

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Sidney	MIDDLE R.	LAST Macon	2a. DATE OF DEATH	MONTH 12	DAY 16	YEAR 83	2b. HOUR 555pM
3 SEX Male	4 RACE Black	5. DATE OF BIRTH	MONTH 08	DAY 27	YEAR 1907	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.								
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipyard		12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 408 N. Avondale Road		21002			
14. FATHER'S NAME FIRST Randolph		MIDDLE	LAST Mason		15. MOTHER'S MAIDEN NAME FIRST Annie		MIDDLE	LAST Macon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 150-07-5455		17 INFORMANT BRENDA J. MACON		ADDRESS 408 N. AVONDALE ROAD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 1590 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic bowel carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> , 19 <u>83</u> , to <u>12-16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Gregory J. Smith</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-16-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory J. Smith		22e. ADDRESS Baltimore City Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/83		23c. NAME OF CEMETERY OR CREMATORY King MEMORIAL PARK		23d. LOCATION CITY OR TOWN RANDALLSTOWN		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME James A. Morton P. H.		ADDRESS 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
IRENE LYDIA MADISON			DECEMBER 24 1983			06:50AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
FEMALE	WHITE	12/18/1916	67 YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
VIRGINIA	U.S.A.				BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL			TECHNICIAN			ELECTRONICS		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			
MARYLAND			BALTIMORE			ESSEX			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
MARVIN			MAUD			MEADOWS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			230.26.6284			EARL L. MADISON			
						ROUTE 3 - BOX 441 ELKTON, VIRGINIA 22827			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>								1/2 hr	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>metastatic carcinoma</u>								2 months	
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>poorly differentiated squamous cell carcinoma</u>								6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
<u>none apparent</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>12/20/83</u> , 19 <u>83</u> , to <u>12/24</u> , 19 <u>83</u> , that (ii) we last saw the deceased alive on <u>12/24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <u>R.M. Hines</u>			DEGREE <u>M.D., Ph.D.</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/24/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.M. Hines</u>			22e. ADDRESS <u>JOHNS HOPKINS Hospital</u> <u>BALTIMORE MARYLAND</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			12/27/1983		ELK RUN CEMETERY		ELKTON, VIRGINIA		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WALTER BROOKS BRADLEY, INC.			DUNDALK, MARYLAND			DEC 28 1983		<u>John J. Conner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4, available retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be properly filled in by the funeral director. Pages 1 and 2 should be detached for use of the burial-transit permit. It has please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

5 116 31 46 7E 9TT 25
VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

RECEIVED
JAN 11 1964



TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

RECEIVED
JAN 11 1964

REC-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32664

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arlene R Magardo			2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 83			2b. HOUR 3:45 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 11 DAY 18 YEAR 32		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Baltimore Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST KARL MIDDLE R LAST Rennenberg			15. MOTHER'S MAIDEN NAME FIRST Pauline MIDDLE R LAST Baume			16. STREET ADDRESS 1904 Angleside Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 016-26-3960		17. INFORMANT ADDRESS 1904 Angleside Rd. Mr. Robert F. Magardo, Fallston, Md. 21047				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4140 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic coronary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 12/20/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery disease			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 83 , to 12/20 , 19 83 , that (I) (we) last saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James Ganey						DEGREE MD		22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES GANEY						22e. ADDRESS Univ. of Md. Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-24-1983		23c. NAME OF CEMETERY OR CREMATORY Highview Mem. Gardens		23d. LOCATION CITY OR TOWN Fallston COUNTY Harford STATE Md.		
24. FUNERAL DIRECTOR NAME E.F. Lassahn ADDRESS 11750 Belair Rd. Kingsville						25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conish	

RECEIVED
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

SEP 28 1954

Mr. Tolson

Mr. E.A. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Harbo

Mr. Mohr

Mr. Winterrowd

Tele. Room

Mr. Holloman

Miss Gandy

Mr. Nease

Mr. Pennington

Mr. Quinn

Mr. Nease

Mr. Egan
Mr. Gurnea
Mr. Hendon
Mr. Jones
Mr. Mumford
Mr. Quinn
Mr. Nease

Mr. Harbo

Mr. Ladd

Mr. Rosen

Mr. Tracy

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Ladd

Mr. Rosen

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Hendon

Mr. Jones

Mr. Mumford

Mr. Quinn

Mr. Nease

Mr. Rosen

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Ladd

Mr. Mohr

Mr. Winterrowd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER Robert Magee				2a. DATE OF DEATH MONTH DAY YEAR 12 13 83				2b. HOUR 9 ¹⁰ P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 22 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Western Elec.		
13a. STATE MARYLAND		13b. COUNTY -----		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 928 S. Ponca St. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Archie Magee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gover							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-03-0417A		17. INFORMANT Catherine W. Magee				ADDRESS 928 S. Ponca St, 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF UNKNOWN PRIMARY</u> 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael J. Fisher MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/13/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. FISHER MD				22e. ADDRESS MERCY HOSPITAL BALTIMORE MD 21202							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-17-83		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 901 S. Conkling St				25a. RECEIVED BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield	

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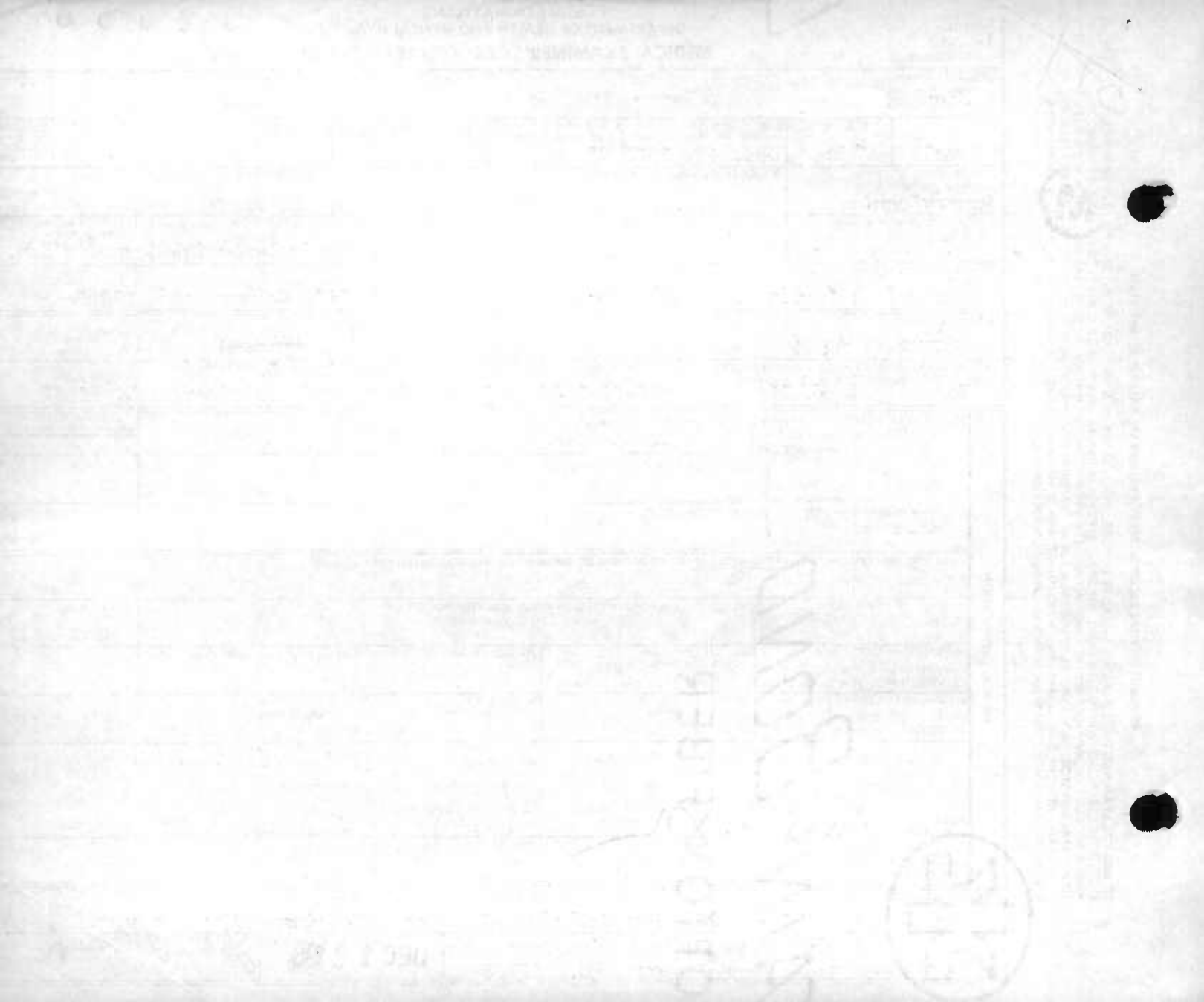
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2. RETURN PAGE 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Stephen Peter Maggio</u>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <u>12</u> DAY <u>14</u> YEAR <u>1983</u>	
2. SEX <u>male</u> 4. RACE <u>White</u> 5. DATE OF BIRTH MONTH <u>Oct.</u> DAY <u>18</u> YEAR <u>1915</u> 6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS. 7. IF UNDER 24 HRS. MONTHS <u>0</u> DAYS <u>0</u> 8. IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>										2b. DATE PRONOUNCED DEAD MONTH <u>12</u> DAY <u>14</u> YEAR <u>1983</u> 2b. HOUR <u>8:57</u> PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u> 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD	
10. CITY OR TOWN OF DEATH <u>Baltimore</u> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Maryland General Hospital</u>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerical- Social Security Adm.</u> 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>The Meadows</u> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <u>1818 Colmar Road 21207</u>											
14. FATHER'S NAME FIRST <u>Santo</u> MIDDLE <u>Maggio</u> LAST <u></u> 15. MOTHER'S MAIDEN NAME FIRST <u>Lena</u> MIDDLE <u>Unknown</u> LAST <u>Bellasai</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>WW 11</u> 16b. SOCIAL SECURITY NO. <u>215-03-1256</u> 17. INFORMANT <u>Mrs. Anna L. Maggio</u> ADDRESS <u>1818 Colmar Road Baltimore, MD. 21207</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK _____ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Ann M. Dixon</u> M.D. <u>Assistant</u> MEDICAL EXAMINER DATE SIGNED <u>12-15-83</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>Ann M. Dixon, M.D.</u> ADDRESS <u>111 Penn St., Balto., Md. 21201</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> 23b. DATE <u>12-19-83</u> 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> 23d. LOCATION CITY OR TOWN <u>Baltimore City</u> COUNTY <u>Maryland</u> STATE _____											
24. FUNERAL DIRECTOR NAME <u>Loring Byers, Funeral Directors, Inc.</u> ADDRESS <u>8728 Liberty Road Randallstown, MD. 21133</u> 25a. DATE REC'D. BY REGISTRAR <u>DEC 16 1983</u> 25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. FOR STATE REGISTRAR								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida K. Magruder					2a. DATE OF DEATH MONTH DAY YEAR 12 20 83			2b. HOUR 2:40p
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 8, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 109 Hilton Avenue 21228		
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Ford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Kelly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-3000		17 INFORMANT ADDRESS Mrs. Virginia M. Dixon Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Atherosclerotic Cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours. Years. Years.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Diabetes Mellitus, Chronic Renal failure								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>on 12-20-19 83</u> , to <u>12-20-19 83</u> , that (I) (we) last saw the deceased alive on <u>12-20-19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE George J. Vellani				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-20-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. VELLANIKARAN M.D.				22e. ADDRESS St. Agnes Hospital 9008 Catonsville Ave. Baltimore MD 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR L. M. & Russell C. Witzke Funeral Homes P. 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE John J. Conner		

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN ALFRED MAJOR, SR.			2a. DATE OF DEATH MONTH DAY YEAR 12/5/83			2b. HOUR 7:15P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 20 14		6. AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber & Welder		12b. KIND OF BUSINESS OR INDUSTRY Local 48	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Major			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Lillian Trivillian			16. STREET ADDRESS 5611 Oakland Road 21227			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 226-03-9259		17. INFORMANT ADDRESS Lillian B. Major 5611 Oakland Rd. 21227				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) End-stage COPD DUE TO, OR AS A CONSEQUENCE OF (c) ~7 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 21 Oct , 19 83 , to 5 Dec , 19 83 , that (I) (we) last saw the deceased alive on 5 Dec , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David Jung			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Jung			22e. ADDRESS 900 Calton Ave St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			24b. ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nicole D. Malecki				2a. DATE OF DEATH MONTH DAY YEAR 12-11-83			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-6-83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 5 days 5	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH D. Malecki				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Debra Cunningham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Joseph Malecki (Same) (Father)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7479 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Persistence of the fetal circulation (c) Group B Beta Streptococcus DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/6, 1983, to 12/11, 1983, that (I) (we) lost the deceased alive on 12/11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Adam A. Rosenberg		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adam A. Rosenberg		22e. ADDRESS SINAI HOSPITAL, BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home		24a. ADDRESS 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

12-11-54

MEMORANDUM

TO :

FROM :



12-11-54

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lorraine Marie Malone			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1983		2b. HOUR 11:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 15, 1895	6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5312 Holder Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Custodian		12b. KIND OF BUSINESS OR INDUSTRY Balt. City	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5312 Holder Ave 21214		
14. FATHER'S NAME FIRST MIDDLE LAST George C Schlesinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmena Bock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-22-7407A		17. INFORMANT ADDRESS Mrs Lorraine M Grauer Same As 13e		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☒ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from **July 1, 1983** to **Dec 24, 1983**, that (I) (we) lost saw the deceased alive on **Dec 24, 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING MEDICAL STAFF
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Donald W. Mintzer MD**3009 Evergreen Avenue Baltimore, Maryland**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/28/83	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
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24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland	25a. DATE REC'D. BY REGISTRAR DEC 28 1983	25b. REGISTRAR'S SIGNATURE <i>James J. Ruck</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1911
No. 1
To the Honorable Secretary of Agriculture
Washington, D. C.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the Act of March 3, 1907, relating to the importation of certain foreign fruits and vegetables.

I am sorry to hear that you are unable to visit the United States at the present time. I am sure that your interest in the subject is fully appreciated. I am sure that you will be able to visit the United States at a later date.

I am, Sir, very respectfully,
Yours very truly,
J. H. ...
Special Agent in Charge

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 6 7 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES P. MANGANELLI			2a. DATE OF DEATH MONTH DAY YEAR 12 4 83		2b. HOUR 1:50^{PM}
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9 25 00		6. AGE (IN YEARS LAST BIRTHDAY) 83 IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse		12b. KIND OF BUSINESS OR INDUSTRY Balto. Envel Co.
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Lakeland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Manganelli		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Liberto			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-03-0113		17. INFORMANT ADDRESS Margaret T. Burkner 710 S. Beechfield Ave. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ATHEROSCLEROSIS, SEVERE 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) OLD MYOCARDIAL INFARCTION (c) AGRANULOCYTOSIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael E. Pelcjar		DEGREE MD		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Pelcjar		22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. NAME OF CEMETERY OR CREMATORY Baltimore			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		24b. ADDRESS 4107 Wilkens Ave.		25a. DEC 7 - 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE H. MANN			2a. DATE OF DEATH MONTH DAY YEAR December 19, 1983			2b. HOUR 4:52 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rental Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Milton M. Mann		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rena Kraut		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 05 8505	
17. INFORMANT Mrs. Estelle M. Mann,		ADDRESS Same					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Cardiovascular disease yrs.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:16
Parkinson's disease

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/8 1975 to 12/19 83, that (I) (we) most saw the deceased alive on 12/8 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Louis E. Grenzer M.D.				DEGREE M.D.		22c. DATE SIGNED 12-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Louis E. Grenzer, M.D.				22e. ADDRESS 1101 N. Calvert St., Balto., MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn MD	
24 FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

GEORGE J. WANN
December 10, 1950
Wife
April 3, 1910
White
U.S.A.
Baltimore City
Union Memorial Hospital
Rental Room 11 East Street
8300 Ellipse Ave. 6151
M.D.
Baltimore
M. Mann
Fon
815 68 5500 Mrs. Estelle M. Mann
Says

My husband is a
Baltimore resident
Dr. J. E. Chaney, M.D.
1101 N. Calvert St., Baltimore, MD
1-22-50
Woodman
Henry W. Jenkins & Sons Co.
1000 York Road, Baltimore, MD 21206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 3 2 6 7 3			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Assunta Marani				2a. DATE OF DEATH MONTH DAY YEAR 12 1 83 2:45 PM			
3. SEX F Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 22 89		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City, Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Petiglio Mastrosati		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsia Capocci					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 185-03-4404		17. INFORMANT ADDRESS Carl D. Marani 56 Tommy True Ct. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) TERMINAL METASTATIC CA- COLON DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ? SEPTICEMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-28-83, 19 to 12-1-83, 19, that (I) lost saw the deceased alive on 11-30-83, 19, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.							
22b. SIGNATURE Khoo		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS KHOO		22e. ADDRESS Good Samaritan Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 3, 1983		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE RECEIVED BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE John J. Conish			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 as any injury, or other traumatic event, the medical examiner must be notified.

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(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES P MARKER					2a. DATE OF DEATH MONTH DAY YEAR December 28, 1983			2b. HOUR M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 121 S. Wolfe St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sea-man		12b. KIND OF BUSINESS OR INDUSTRY Maritime			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY - -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST -? unknown. - Marker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia - Sinners					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-14-5851		17. INFORMANT ADDRESS Sophia Wilkens 121 S. Wolfe St. (21231)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Cancer of bladder DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder CA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1982 , to 12/ , 19 83 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.										
22b. SIGNATURE Fry F. Marshall DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Dec. 28, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Fry F. Marshall,					22e. ADDRESS 600 N. Wolfe St./ Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1983		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co., Md.			
24 FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 1901 Eastern Ave./21231					25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Conrad			

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 6 7 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABEL			2a. DATE OF DEATH MONTH DAY YEAR December 8, 1983			2b. HOUR 6:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3219 Chesley Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Novelty Co.	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3219 Chesley Ave. 21234		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Holmes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Ford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-07-4334		17. INFORMANT Virginia L. McCoy			ADDRESS 21220 Dihedral Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CVD 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Epilepsy									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from April 16, 1983 to Dec 8, 1983 , that (I) (we) last saw the deceased alive on April 19, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Donald Jandorf					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 9, 1983
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Donald Jandorf					22e. ADDRESS 7403 Harford Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 12, 1983		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214					25. DATE REC'D. BY REGISTRAR DEC 12 1983				
26. REGISTRAR'S SIGNATURE John J. Lander									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISAAC M. MARSH Jr.			2a. DATE OF DEATH MONTH DAY YEAR December 25, 83		2b. HOUR MIN. 6:00 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital, Balto. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Construction Eng.)		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Isaac M. Marsh, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeda --- Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 218-03-6593		17. INFORMANT ADDRESS Mrs. Frances M. Marsh, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Congestive Heart failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Atherosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypoxia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, Cerebrovascular disease.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-13-1983 to 12-25-1983 , that (we) last saw the deceased alive on 12-25-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Geary J. Vellawakar		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-25-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. VELLANIKARAN		22e. ADDRESS 31. Agnes Hospital 9005. Catow Avenue. Balto MD 21228				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland
24. FUNERAL DIRECTOR NAME Maully Funeral Home, 237 E. Patapsco Ave. Balto.		ADDRESS MD. 21225		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		
				25b. REGISTRAR'S SIGNATURE John J. [Signature]		

BP

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

ANDREW D. LEECH, PRINTER

1901

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

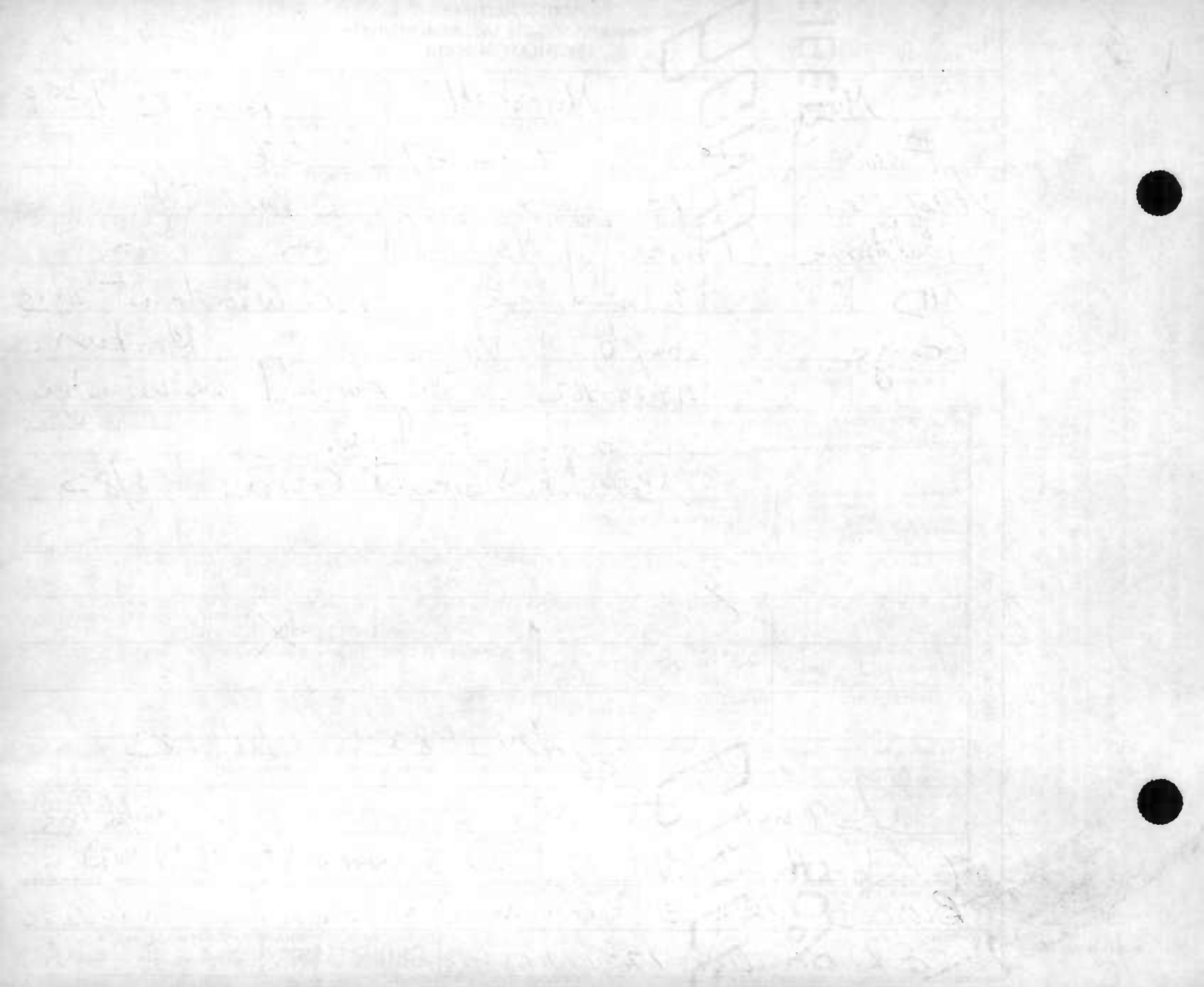
1. DECEASED NAME (TYPE OR PRINT) Mary Marshall			2a. DATE OF DEATH MONTH DAY YEAR 12 25 83		2b. HOUR 1 50 P
1. SEX Fem	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 12 27		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 0		12b. KIND OF BUSINESS OR INDUSTRY 0
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Brickers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. 219-28-362		17. INFORMANT ADDRESS Sandra Marshall 1306 W Saratoga			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Respiratory Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Breast Cancer (c) 8/83 DUE TO, OR AS A CONSEQUENCE OF: (a) Respiratory Failure. (b) Metastatic Breast Cancer (c) 8/83					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 83 , to 12/25 , 19 83 that (I) (we) lost saw the deceased alive on 12/25 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Jonathan D. Root MD		DEGREE MD		22c. DATE SIGNED 12/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan D. Root MD		22e. ADDRESS 22 S. Green St. Balt MD.			
23a. BURIAL CREMATION, REMOVAL (SPECIFY)	23b. DATE 12/29/83	23c. NAME OF CEMETERY OR CREMATORY Baetia Nat. Cemet.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME E. L. Phillips		ADDRESS 1721 N. Mount		25a. DATE REC'D. BY REGISTRAR DEC 27 1983	
25b. REGISTRAR'S SIGNATURE John L. Carrick					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be signed by the medical examiner.

BP.



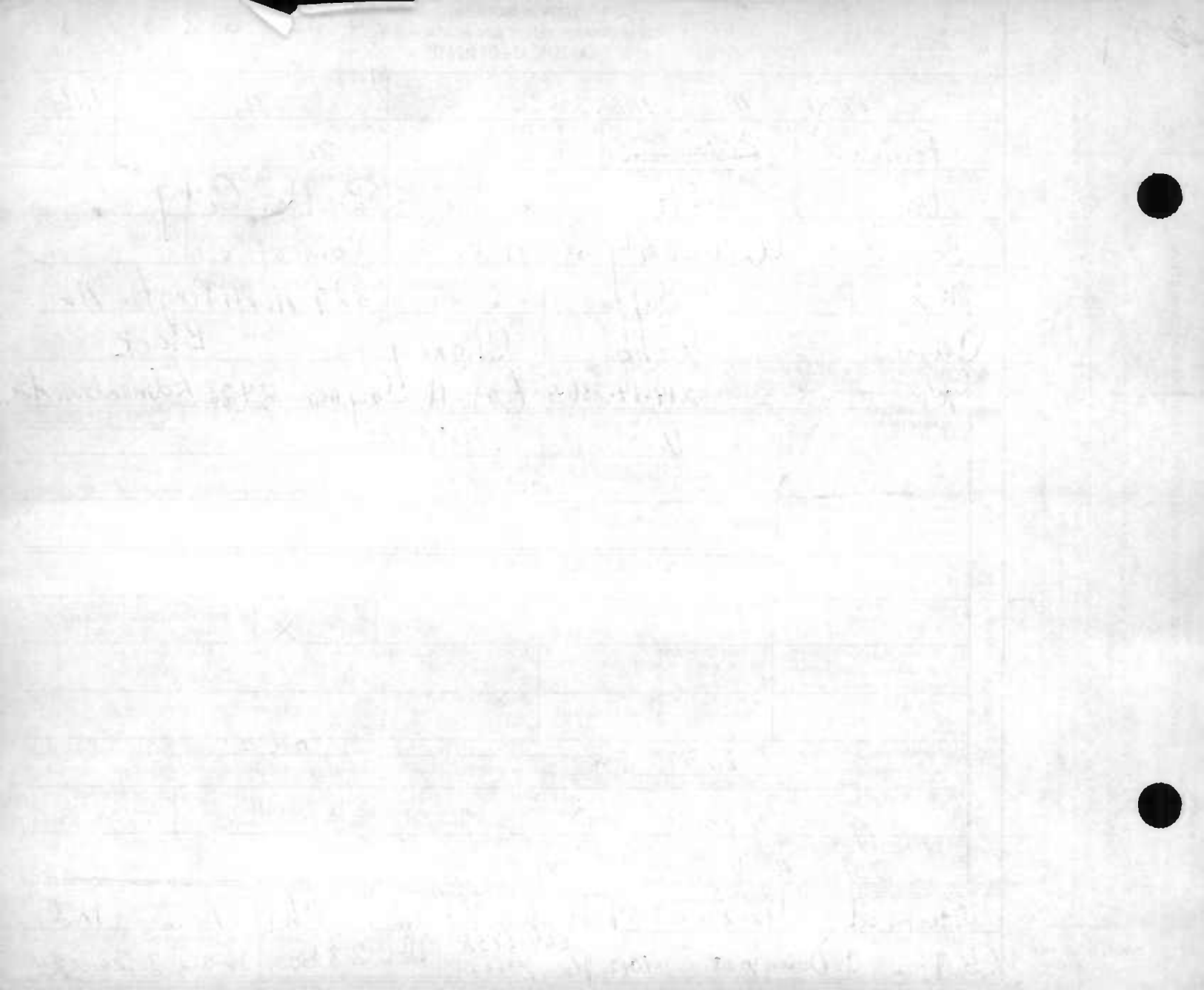
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MARY M. MARSHALL</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-21-83</i>		2b. HOUR <i>1:16p</i>	
3. SEX <i>Female</i>	4. RACE <i>Negro</i> Caucasian	5. DATE OF BIRTH MONTH DAY YEAR <i>8 30 03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i>		
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Md.</i>		12a. USUAL OCCUPATION (THROUGH WORK FOR MOST OF WORKING LIFE) <i>domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <i>827 N. Arlington Ave. 21207</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Webb</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Chaney Black</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-14-2363</i>		17. INFORMANT ADDRESS <i>Odell Joyner 2428 Edmondson Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>asystole</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>DEC 21</i> , 19 <i>83</i> , to <i>DEC 21</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Dec 21</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John Vitarello MD</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/21/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN A. VITARELLO MD</i>		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE <i>12-27-83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cheltenham Vet Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cheltenham Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Carlton C. Douglass</i>		ADDRESS <i>669-1738 1012 Penn Ave.</i>		25. DATE REC'D. BY REGISTRAR <i>DEC 23 1983</i>		
		25b. REGISTRAR'S SIGNATURE <i>John J. Carcich</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 3 2 6 7 9	
1. FOR STATE REGISTRAR REGINA C. MARTIN				CERTIFICATE OF DEATH	
2. DECEASED NAME a. (TYPE OR PRINT) Regina C. Martin				2b. DATE OF DEATH MONTH DAY YEAR 12-5-83	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-16-04	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST John Charles McGinnie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Wilhemina Kothe		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Social Security Adm.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-3070		17. INFORMANT Sister Annella Martin, Baltimore, Md. 21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 13 yrs. ⊕	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 83 , to 12/5 , 19 83 , that (I) (we) last saw the deceased alive on 12/5 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE F. Wiegmann MD				22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. Wiegmann				22e. ADDRESS 301 St. Paul Pl. / Balto., Md. 21202	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR'S NAME Leta M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR DEC 6 1983	
24b. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228				25b. REGISTRAR'S SIGNATURE [Signature]	

BP



REGINA C. MARTIN

Female

White

Martin

71

11122 Boone Lane

11122 Boone Lane

Hospital

11122 Boone Lane

11122 Boone Lane

John

Charles

Regina

11122 Boone Lane

11122 Boone Lane

11122 Boone Lane

Myocardial Infarction

Coronary Artery Disease

2 days

15 min

20% CO2



X

12/2/83

11122 Boone Lane

11122 Boone Lane

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Forrest Martin			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12-7 1983		2b. HOUR M 10:38 a. M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 17 1923	6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-7 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U. S. A.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Sorter	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) World War II 297-12-9062		17. INFORMANT ADDRESS 3409 Aurora Lane Juathawala J. Harris Balto. Md. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 12-7-83	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/1983		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem	
24. FUNERAL DIRECTOR NAME INTER & SONS		25a. ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216		25b. DATE REC'D. BY REGISTRAR DEC 13 1983	
25c. REGISTRAR'S SIGNATURE <i>John J. Carver</i>					

COUNTY STATE

Baltimore, Maryland



RECEIVED

NOV 19 1953

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

2
1
1
1
1



NOV 19 1953

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR **CLARA MAY MARTINEZ**

1. DECEASED NAME (TYPE OR PRINT) Clara May Martinez			2a. DATE OF DEATH MONTH DAY YEAR 12 24 83			2b. HOUR 5:49 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 14 28		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. mo		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD Hosp				12a. USUAL OCCUPATION (TYPE OR MOST OF WORK (IFE)) Nurse Aide		12b. KIND OF BUSINESS OR INDUSTRY Nursing Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) TEXAS XXXX			13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 800 E. FIR STREET 78501		
14. FATHER'S NAME FIRST MIDDLE LAST Charles XXXXXX HERGET			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret XXXXX MAY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NUMBER 219-20-5994			17. INFORMANT ADDRESS WILHELMINA CHANEY 129 E. WEST STREET BALTIMORE, MARYLAND 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Probable ovarian cancer DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Probable rectal cancer; Pyloric Ulcer									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/22 , 19 83 , to 12/24 , 19 83 , that (I) (we) lost saw the deceased alive on 12/24 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph J Panos MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph J Panos MD			22e. ADDRESS Univ of MD Hosp 22 Greene St						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/27/1983		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their please remove carbonpapers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 326822	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George A. Masel, Jr.						2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1983			2b. HOUR 3:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 3, 1906		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 77 YRS.		IF UNDER 1 YEAR HOURS MIN.		IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3013 Pulaski Highway-		21224.	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Masel, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Knight							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT ADDRESS Baltimore, Md. 21224. Joseph A. Masel-110 N. Curley St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Atherosclerotic Cordia Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peripheral Arterial Insufficiency											
19a. DATE OF OPERATION 12-12-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bypass Left foot			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-30 19 83 to 12-27 19 83, that (I) (we) last saw the deceased alive on 12-27 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE Rolando V. Goco MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED 12-27-83	
24a. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando V. Goco, MD						24b. ADDRESS 707 E. Fort Ave, Balt. Md 21230					
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			25b. DATE 12/29/83		25c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery-Baltimore, Maryland			25d. LOCATION CITY OR TOWN COUNTY STATE			
26. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home 3000 E. Baltimore St.; Balto., Md. 21224						DATE REC'D. BY REGISTRAR DEC 29 1983		26b. REGISTRAR'S SIGNATURE John J. Conner			

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CHIEFLY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

HILDRED ADAM MASON

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST HILDRED ADAM MASON			MONTH DAY YEAR 12-24-83			6:30p M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE			7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	WHITE	MONTH DAY YEAR 10 10 1920		63 YRS.			BALTIMORE CITY, MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
VIRGINIA	U.S.A.			MECHANIC			AUTO DEALER	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12c. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			BALTIMORE CITY HOSPITALS			AUTO DEALER		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			BALTIMORE			BALTIMORE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST SAM MASON			FIRST MIDDLE LAST HATTIE DONETHAN			3889 SINCLAIR LANE 21213		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
YES			WW II			FRANCES C. MASON (same as 13e)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SEPTIC SHOCK

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-24, 19-83, to 12-24, 19-83, that (I) (we) last saw the deceased alive on 12-24, 19-83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Daniel M. Perlman		MD		12/24/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED			
DANIEL M. PERLMAN		BALTIMORE CITY HOSPITALS		12/24/83			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		12/26/1983		GREEN MOUNT CEMETERY		BALTIMORE CITY, MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WALTER BROOKS BRADLEY, INC. BALTO., MD				DEC 28 1983		John J. Canick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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13 24 1971

RECEIVED

General Post Office, London

DANIEL M. FORDMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

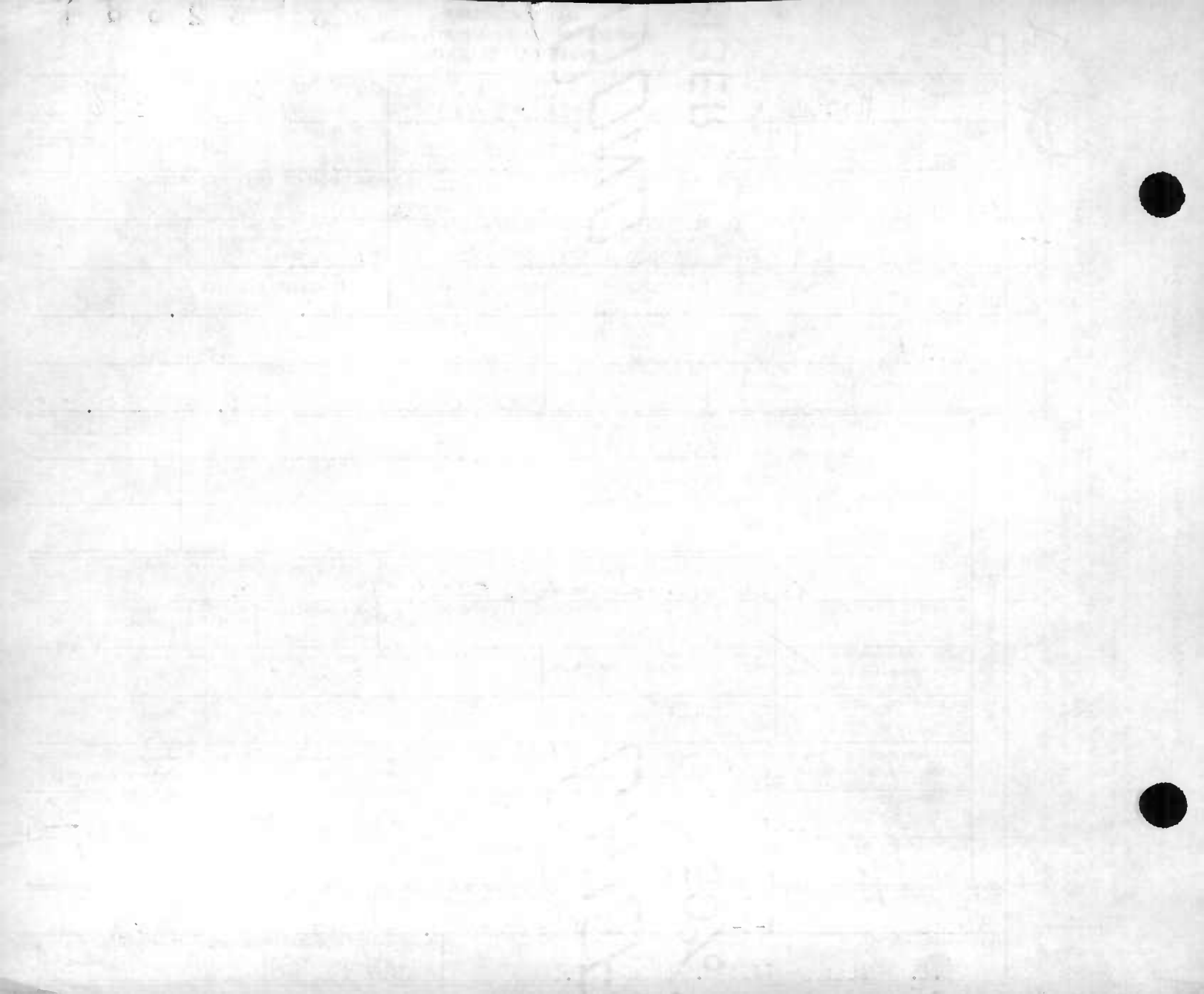
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WARREN MASON			2a. DATE OF DEATH MONTH DAY YEAR 12-30-83		2b. HOUR 6 02 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 31 25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR MASON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA FERGURSON		13e. STREET ADDRESS / ZIP CODE 10 N. MONROE ST. 21223		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RUSSELL MASON 10 N. MONROE ST. 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Gastrointestinal bleeding						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 83 , to 12/30 , 19 83 , that (I) (we) lost saw the deceased alive on 12/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE M. J. Giesbreman		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/30/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. J. Giesbreman		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-5-84		23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS E.L. PHILLIPS 1721 N. MONROE ST.				25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE John J. Smith

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) DOROTHEA L MASSERON					2a. DATE OF DEATH MONTH DAY YEAR 12 20 83				2b. HOUR 725^{PM}
3. SEX Female	4. RACE White Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 7 23 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH B. City Baltimore City, Md.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. Maryland Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Western Elec.			
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5965 Bendon Heights Ave 21206				
14. FATHER'S NAME FIRST MIDDLE LAST Paul Lavardera			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-4878		17. INFORMANT ADDRESS Judy Nawrozki 1320 Kenton Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 4273 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Ascites 2° transitional cell CA bladder + mets (c) atrial fibrillation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: hemolytic microcytic anemia + PPD pleural effusions									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/16 , 19 83 , to 12/20 , 19 83 , that (1) (we) last saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] MD				DEGREE		22c. DATE SIGNED 12.20.83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KMET20				22e. ADDRESS Univ. Maryland Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 24, 83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Doppel Funeral Homes, Inc.				ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

DATE: 12-15-53

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		20. DATE OF DEATH		MONTH		DAY		YEAR		26. HOUR	
ATTILIO		J.		MAULONE		12/10/83								4:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
M		WHITE		MONTH DAY YEAR 5 16 1920		63		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
OHIO		U.S.A.				Baltimore City								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		SINAL HOSPITAL		Retired -		Beth. Steel									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		226 S. CONKLING ST						21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST Enrico		FIRST MIDDLE LAST Julia												Guilano	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		214 18 3643		Phyllis Maulone		226 S. Conkling St								21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARIOPULMONARY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1519		DUE TO, OR AS A CONSEQUENCE OF												6 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		ADENOCARCINOMA OF STOMACH											
		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		Abdominal aneurysm													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
4/23/83				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>83</u> , to <u>12/10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED									
Kang Sun Lee						12/10/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
KANG SUN LEE		SINAL HOSPITAL													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		12-13-83		Oaklawn Cem.		Baltimore Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Joseph N ZANNINO		21224 263 S. Conkling St.		DEC 14 1983		John J. Conkling									

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UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1. Name of the plant or animal: *...*
2. Locality: *...*
3. Date of collection: *...*
4. Collector: *...*
5. Description: *...*
6. Remarks: *...*

7. Distribution: *...*
8. Uses: *...*
9. Other notes: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be looked up at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONARD J. MAUS SR.			2a. DATE OF DEATH MONTH DAY YEAR 12-14-83			2b. HOUR 1910 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 07 14 37		6. AGE (IN YEARS LAST BIRTHDAY) 46		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2119 Ramsay St. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Maus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Vaeth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO			
16b. SOCIAL SECURITY NO. 216-34-778		17. INFORMANT ADDRESS Bertha Maus 2119 Ramsay St. Balt., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma with</u> <u>1729</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Brain metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>83</u> , to <u>12/14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert M. Sabunow</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT M. SABUNOW				22e. ADDRESS Bon Secours Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-19-83		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR Nick Mavroukas

DECEASED NAME (TYPE OR PRINT) NICK NMM MAYROUKAS			2a. DATE OF DEATH MONTH DAY YEAR 12 22 83			2b. HOUR 6:05 P.M.	
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 - 18 - '35		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. STATE MD				13b. CITY OR TOWN Brooklyn		13c. STREET ADDRESS 316 - HAILE ROAD, 21225	
FATHER'S NAME FIRST MIDDLE LAST Kuriakos MAYROUKAS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kostoula Kalamaras			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-32-9399		17. INFORMANT Mrs Venetia Mavroukas Same as 13c			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) CA LUNG - PNEUMONITIS - ANEMIA.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 12-21-1983, to 12-22-1983, that (we) last saw the deceased alive on 12-22-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cham Mavroukas				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF HOUSE PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MODNPRA MAHECH				22e. ADDRESS 1028 Rusling Oaks drive millers wife MD 21108			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 12/26/83		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto Md	
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24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonc 4001 Ritchie Hgwy Balto, Md				25. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie H. Max			2a. DATE OF DEATH MONTH DAY YEAR 12 21 83			2b. HOUR 3 P.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 08 10 93		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT HACK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE LACKIER		13e. STREET ADDRESS 3501 St. Paul St		APT. 748 21218	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 01 9734		17. INFORMANT MR. SYLVAN HACK		ADDRESS 6202 IVYMOUNT RD. BALTO., MD 21209	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute abdomen - probable perforated ulcer

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Hip fracture

19a. DATE OF OPERATION 12-15-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left hip fracture		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 12-15-83, 19, to 12-21, 19-83, that (we) lost saw the deceased alive on 12-21, 19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE IRA BLECKER		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-21-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA BLECKER		22e. ADDRESS Sinai Hospital of Baltimore					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

WATER-PROOF
MADE IN U.S.A.
100% COTTON



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE MAXWELL				2b. HOUR 5:25 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 13 03		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY HOUSEMAKER	
13a. STATE MD.				13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS 7662 OLD BATTLE CR. RD.	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN				16b. SOCIAL SECURITY NO. 212-10-1949		17. INFORMANT ADDRESS BCH MEDICAL RECORDS BAL, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) CARDIAL ARREST 2900 DUE TO, OR AS A CONSEQUENCE OF (b) ANOMALOUS COHA 2° ASPIRATION OF GASTRIC CONTENTS DUE TO, OR AS A CONSEQUENCE OF (c) DEMENCIA → ASPIRATION							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 214-22-0162							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 83 , to 12-12 , 19 83 , that (I) (we) lost saw the deceased alive on 12-12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Yang		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW YANG M.D.		22e. ADDRESS BALTIMORE CITY HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/15/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME MARYLAND BOARD OF ANATOMY				25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

332091
32691FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mildred M. May.			2a. DATE OF DEATH MONTH DAY YEAR Dec. 9, 1983			2b. HOUR M 11			
3. SEX Female.		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept 24, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memoria 1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1410 Dellwood Ave. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Croft.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Simmons.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----				16b. SOCIAL SECURITY NO. ----- 213-05-9260B		17. INFORMANT ADDRESS Elmer L. May. 1410 Dellwood Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

4148

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) **atherosclerotic coronary Art. Dis.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 12/12 , 19 83 , to Dec 9 , 19 83 , that (I) (we) lost saw the deceased alive on 12/12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward L. Glassman MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD L. GLASSMAN MD		22e. ADDRESS 4037 FALLS RD BALTO. MD 21211					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE Dec. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Dover Meth. Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co.	
24. FUNERAL DIRECTOR NAME ADDRESS Paul E. Chenoweth 3615-17-19 Chestnut Ave.				25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE DEC 12 1983 John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

• 758 •

657 7.9

22

• **Chlorine**

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• **OTC**

1. *Strongly Oppose*

• *W. J. W. J.*

• 97K BOOKING OLD

• 450

524

• **misconduct** *n* **scf**

• 1070 •

213-05-8688 - Room 1, 1110 Bellwood Ave.

100-131871-107

Mr. E. J. Connelley, 3015-17-19, Cleveland, Ohio.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		December 14, 1983	
DOROTHY		MCALLISTER				2:28a _M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female	black	5 MONTH 27 1903		80 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY	
Va	U S A			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12c. STREET ADDRESS / ZIP CODE		13. INSIDE CITY LIMITS?		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		3401 Holmes 21217		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	14. FATHER'S NAME				
Md		Baltimore	William Warren				
15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				
Odie Downing			16b. SOCIAL SECURITY NO.				
			213-30-2238				
			17. INFORMANT				
			Doris Neal 3401 Holmes Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>							
5698 DUE TO, OR AS A CONSEQUENCE OF							
(b) <i>overwhelming sepsis / pneumonia</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>colon perforation</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
<i>Peritonitis / colonic bleed</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10/22/83</i> to <i>12/14/83</i> , that (I) (we) lost saw the deceased alive on <i>12/14</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<i>M.G. Threlkeld</i>		MD		<i>12/14/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
M.G. Threlkeld		Johns Hopkins Hospital Balt. MD.		Burial			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
12/17/83		Woodland Cemetery		Baltimore Co Md			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William C. March F/H 1101 E. North Ave		DEC 15 1983		<i>John J. Connel</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THOMAS CRAWFORD McASLAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16, 1983		2b. HOUR 5:15 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 29, 1923	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? Scotland	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medical
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6003 Lakehurst Dr. 21210	
14. FATHER'S NAME FIRST MIDDLE LAST John McAslan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Crawford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214 46 8233	17. INFORMANT ADDRESS Evelyn R. McAslan, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) renal & hepatic failure (c) metastatic carcinoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 weeks 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1991					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from November 19, 93 to December 16, 1983 , that (I) (we) lost saw the deceased alive on December 16, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Timothy G. Buchman		DEGREE MD		22c. DATE SIGNED 12/16	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY G. BUCHMAN		22e. ADDRESS 600 N. WOLFE ST. BALTO. MD. JOHNS HOPKINS HOSPITAL 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12/17/83	23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR DEC 19 1983		

BP _____



Creation
Henry W. Jenkins & Sons Co.
200 York Road, Baltimore, Md. 21212

500 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

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100 N. Wolfe St. Baltimore, Md.

100 N. Wolfe St. Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Ashley Marie Matthews McClaskey								12 19 83		2:10 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE	WHITE	12 18 83		0 YRS.		0 MONTHS 0 DAYS		70 HOURS 70 MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Baltimore City Hospitals				-----		-----		
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS				
Maryland		Baltimore		Chase		6721 Cornell Rd, 21220				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
David Dion McClaskey		Sandra Lee Matthews								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No		None		Chase, Maryland						
				Sandra L. Matthews 6721 Cornell Rd. 21220						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ASPHYXIA										
7766 DUE TO, OR AS A CONSEQUENCE OF, (b) RESPIRATORY FAILURE										BIRTH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PREMATURITY										"
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
BRBCH, ANEMIA, ACIDOSIS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
NA		NA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
NA		HOUR A.M. MONTH DAY YEAR		NA						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
NA		NA		NA						
22a. I certify that (I) (this hospital) attended the deceased from 12-18 19 83, to 12-19 19 83, that (I) (we) last saw the deceased alive on 12-19 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
E. J. Burroughs M.D.						12-19-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
E. J. Burroughs M.D.		Baltimore City Hosp.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial		12/21/83		Moreland Mem. Pk.		Parkville, Balto. Co. Md.				
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Martin D. Lawson		DEC 21 1983		John J. Burroughs						
25c. ADDRESS										
10 W. Padonia Rd. Timonium										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie Laurie McClellan ANNIE LOUISE McCLOLLAN		2a. DATE OF DEATH MONTH DAY YEAR 12/23/83 2b. HOUR 538 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 14 1901	
7a. BIRTHPLACE (STATE OR FOREIGN) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		12b. KIND OF BUSINESS OR INDUSTRY Home	
13b. CITY OR TOWN Colgate		13c. STREET ADDRESS 484 Mirable Lane 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Lafon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 231 05 5314	17. INFORMANT ADDRESS June Hawks 5 Crafton Rd. Balto. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN - with Electro-mechanical Disturbance (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Status Post (R) GVA, Hypertension, History Bundle Branch Block			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/23/83 to 12/23/83, that (I) (we) lost the deceased alive on 12/23/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Rudolph E. M. B. K. K.	DEGREE MO	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/23/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudolph E. M. B. K. K.		22e. ADDRESS Carey Baltimore City Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/27/83	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Md.
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	25b. REGISTRAR'S SIGNATURE John J. Connelley

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
E. ESTELIA E. MCCLURKIN			NOVEMBER 12, 1983			11:30A.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	Black	10 3 14	69 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
N. Carolina	U.S.A.		Baltimore City, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Church Home Hospital							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Baltimore			Baltimore		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Charles Reaves			Lula Flowers			N/A		
17. INFORMANT			ADDRESS			Apt. 901		
Shirley McClurkin			1100 N. Bolton St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)								
1790 METASTATIC CARCINOMA UTERUS								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from NOVEMBER 7, 1983, to NOVEMBER 12, 1983, that (I) we last saw the deceased alive on NOVEMBER 12, 1983, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) did not view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
A. F. NAZEMI						11/12/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
A. F. NAZEMI			CHURCH HOSPITAL CORPORATION					
XXXXXXXXXXXXXX			100 N. BROADWAY, BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (S)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			11/16/83			Balto. National Cem		
23d. LOCATION			23e. COUNTY			23f. STATE		
Baltimore			Md.					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS			NOV 14 1983			John J. Conner		
Wm C March F/H Inc. 1101 E North Avenue								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral home. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



WELLMAN

100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Cleotis McCollum					2a. DATE OF DEATH MONTH DAY YEAR December 31, 1983			2b. HOUR P 12:06 M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 24 51		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21216 1812 Poplar Grove Street	
14. FATHER'S NAME FIRST MIDDLE LAST Eddie Calvin Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McCollum				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-58-5898		17. INFORMANT ADDRESS Annie Privette 1812 Poplar Grove St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4293 Marked cerebral congestion, and extensive brain stem necrosis. DUE TO, OR AS A CONSEQUENCE OF (b) Clinical history of cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial hypertrophy (750 grams) weight.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic cardiovascular disease.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 23, 1983 , to December 31, 1983 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 31, 1983 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Karen Y. Trent, M.D.					DEGREE Attending Physician		22c. DATE SIGNED 1/3/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karen Y. Trent, M.D.					22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/7/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and one of the following must be completed and filed with this certificate: 1. A report from the medical examiner, or 2. A report from the medical examiner, or 3. A report from the medical examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STONISLEE

Information Internal to the Bureau

உதவி: எழுந்திருக்க

METHOD

sites

December 31, 1983

20-51

Marked cerebral congestion, and extensive brain edema.

Clinical history of cardiovascular arrest

Neuronal hypertrophy (750 grams) weight.

pericarditis, myocardial infarction, and atherosclerosis.

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

December 31	83	December 31	83
X			

83 100-100-100 31 83

10/3/5

C/o General Hospital

RECEIVED . Y. THOMAS . M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>William M. Conkey</u>					2a. DATE OF DEATH MONTH <u>12</u> DAY <u>7</u> YEAR <u>83</u>			2b. HOUR <u>M</u>	
3. SEX <u>M</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>7</u> DAY <u>21</u> YEAR <u>52</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.			
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>2317 W. Lawrence St</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Salesman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>2317 W. Lawrence St</u>		
14. FATHER'S NAME FIRST <u>Mark</u> MIDDLE <u></u> LAST <u></u>					15. MOTHER'S MAIDEN NAME FIRST <u>Ann</u> MIDDLE <u></u> LAST <u></u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>					16b. SOCIAL SECURITY NO. <u>213-30-7867</u>		17. INFORMANT ADDRESS <u>Joy Hanny 2317 W. Lawrence St</u>		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>? hours</u> <u>104 AS +</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIA BETES</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>83</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>6-2</u> , 19 <u>77</u> , to <u>11-21</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>John T. Chissell</u> , MD					DEGREE <u>MD</u>			22c. DATE SIGNED <u>12/9/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN T. CHISSELL, MD</u>					22e. ADDRESS <u>940 W. NORTH AVE BALTIMORE, MD 21217</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>12/12/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>MD</u> STATE <u></u>		
24. FUNERAL DIRECTOR <u>Manly P. Hahn</u> ADDRESS <u>6387 51st Ave</u>					25a. DATE REC'D. BY REGISTRAR <u>DEC 15 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John T. Chissell</u>		

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 6 9 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy J. McCray</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 10 83</i>		2b. HOUR <i>8:15 P.M.</i>	
3. SEX <i>F</i>	4. RACE <i>BL</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 11 36</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>46</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balt.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Univ. of Md. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD.</i>		13b. COUNTY <i>City</i>	13c. CITY OR TOWN <i>Balt.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William J. Benson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katie (Benson) Lagroom</i>		16. STREET ADDRESS <i>606 N. Augusta Ave.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-36-6894</i>		17. INFORMANT <i>John McCray</i>	
16c. ADDRESS <i>606 N. Augusta Ave</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac Arrest*
7591
DUE TO, OR AS A CONSEQUENCE OF
(b) *Sepsis, Renal Failure*
DUE TO, OR AS A CONSEQUENCE OF
(c) *Chronic Hypertension*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>11/15</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sepsis</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/63</i> , 19 <i>83</i> , to <i>12/10</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12/10</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>William C. March</i>		22c. DATE SIGNED <i>12/10/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William C. March</i>		22e. ADDRESS <i>Univ. of Md. Hosp. 714</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12/15/83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i>

24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 1101 E. North Ave

25a. DATE REC'D. BY REGISTRAR
DEC 14 1983
25b. REGISTRAR'S SIGNATURE
John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANK MCCULLOUGH			2a. DATE OF DEATH MONTH DAY YEAR 12/06/83		2b. HOUR 8:25PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker	
12b. KIND OF BUSINESS OR INDUSTRY Armco		13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur McCullough		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 12 6278	
17. INFORMANT ADDRESS Robert McCullough 1210 F Bride Crossing Rd. 21221		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic obstructive pulmonary disease (c) Smoking		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			

MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

ventricular ectopy, multifocal atrial tachycardia, acute upper gastrointestinal bleed

19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- --- 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) ---			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---		21f. LOCATION STREET CITY OR TOWN COUNTY STATE --- --- --- ---			
22a. I certify that (1) (this hospital) attended the deceased from 12/1 , 19 83 , to 12/6 , 19 83 , that (1) (we) lost saw the deceased alive on 12/6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maura McGuire		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maura McGuire		22e. ADDRESS 1620 McElderry St #905					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 9 1983		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 700 S. Conkling St. 21224				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conish	

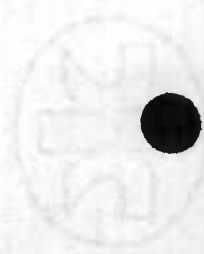
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
TO: [Illegible]

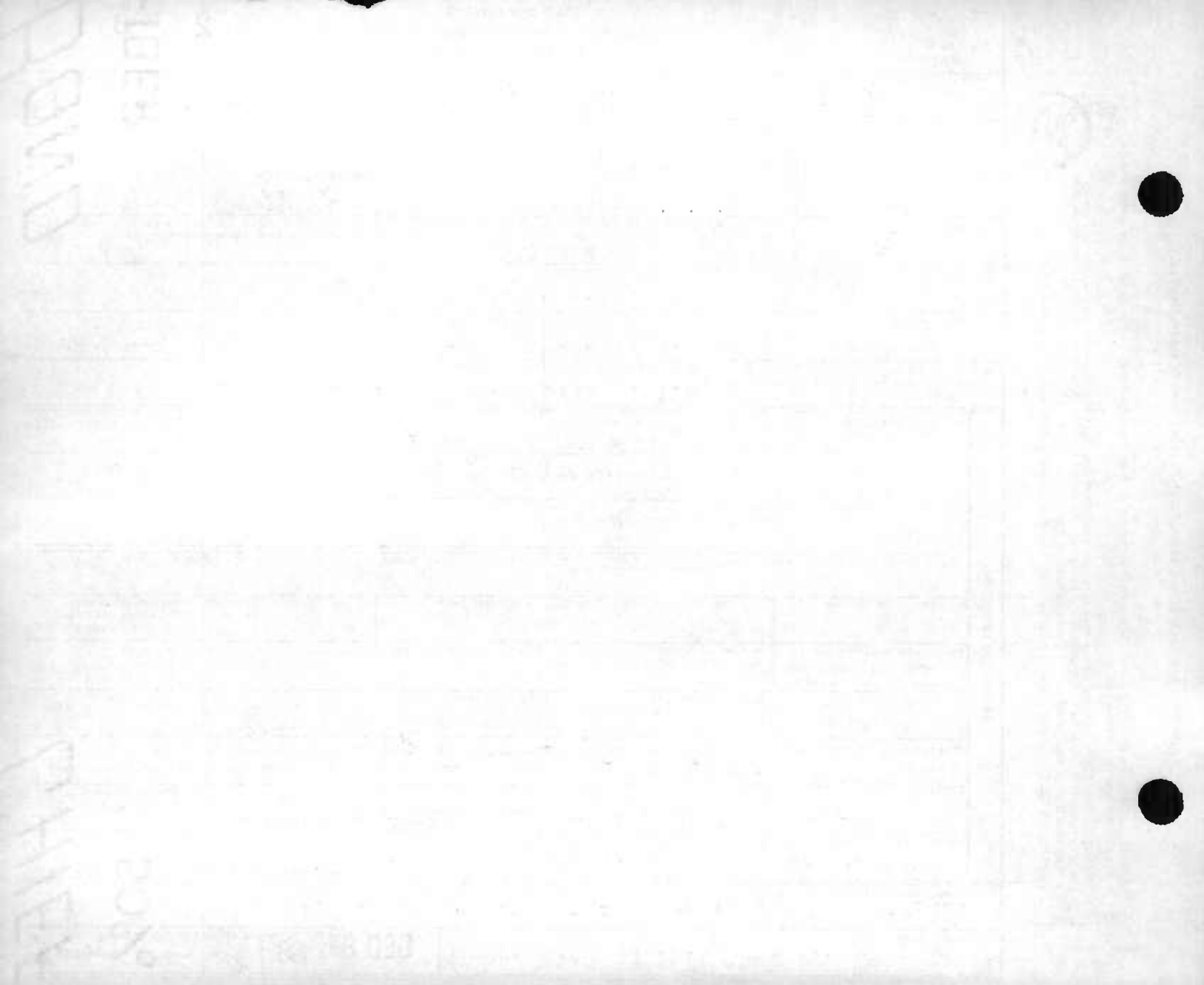
[Illegible text block containing several paragraphs of a memorandum, likely detailing a report or action item.]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 07 83		2:20 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		MONTH DAY YEAR 2 15 20		63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S. Carolina		U.S.A.				Baltimore city MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
city		BON SECOURS HOSPITAL					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
Maryland				Baltimore		2529 W. Lombard St. 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Thomas McCullough		FIRST MIDDLE LAST Amy Crawford		NO		251-18-5115	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>1539</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA of Colon with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>83</u> , to <u>12/07</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Kuang-yen Huang MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/7/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE	
KUANG-YEN HUANG		BON Secours Hospital		BURIAL		12/10/83	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Arbutus Memorial		Pk. Arbutus, MD.		Arbutus Memorial		Pk. Arbutus, MD.	
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue		DEC 8 - 1983		John J. Conner			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 7 0 2	
1. DECEASED NAME (TYPE OR PRINT) Charles McCurdy						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/4/83		2b. HOUR 4:30		2c. DATE PRONOUNCED DEAD 12/4/83	
1. SEX M	4. RACE Negro	5. DATE OF BIRTH MONTH 2 DAY 6 YEAR 43	6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	7c. DATE PRONOUNCED DEAD 12/4/83		7d. HOUR P		7e. MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY 			
13a. STATE M.D.						13b. COUNTY 		13c. CITY OR TOWN BAITO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Charles MIDDLE LAST McCardy						15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE LAST Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-38-1235		17. INFORMANT ADDRESS Mrs. Florence Brown 613 McCab Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Incised Wounds Head and Neck 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). 											
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 1:00 AM 12/3/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject stabbed					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, ETC.) parking lot		21f. LOCATION 5600 York Road, Balto. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. TITLE (SPECIFY) Assistant	
ACTUAL SIGNATURE Dennis F. Smyth M.D.				DATE SIGNED 12/5/83				22c. MEDICAL EXAMINER Dennis F. Smyth, M.D.			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY BAITO. Cem.		23d. LOCATION CITY OR TOWN BAITO. COUNTY M.D. STATE M.D.			
24. FUNERAL DIRECTOR NAME Betts Funeral Home ADDRESS 1129 N. Caroline St						25a. DATE REC'D. BY REGISTRAR DEC 8 - 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

BP



RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Lillian M. McMahon			2a DATE OF DEATH MONTH DAY YEAR 12 - 3 - 83			2b HOUR 11:00PM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 02/09/1896		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY		13c CITY OR TOWN Baltimore		13d STREET ADDRESS 2745 Wilkens Avenue 21223			
14 FATHER'S NAME FIRST MIDDLE LAST Frank Weaver			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Leonard							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213348542		17 INFORMANT Front Sheet				ADDRESS	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 7070 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Sepsis	
DUE TO, OR AS A CONSEQUENCE OF		(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION 11/18/83		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Extensive Decubitus Ulcer		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY N.A. HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A.			
21d INJURY OCCURRED NA WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY N.A. (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION N.A. STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/19, 1983, to 12/3, 1983, that (I) (we) last saw the deceased alive on 12/3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Samir A. Dalal				DEGREE		22c DATE SIGNED 12/3/83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SAMIR A. DALAL				22e ADDRESS ST. AGNES HOSPITAL 900 S. Calver Ave.			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 12/06/83		23c NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Rd.				25a DATE REC'D BY REGISTRAR 12/5/83 25b REGISTRAR'S SIGNATURE John J. Conner			

1940-1941

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

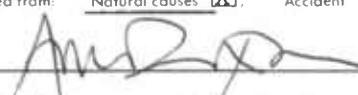

1957-1958

1958-1959

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DANIEL MC FADDEN										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 29 YEAR 1983	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 4 DAY 18 YEAR 06	6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7c. DATE PRONOUNCED DEAD MONTH 12 DAY 29 YEAR 1983		7d. HOUR 4:24			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp. (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 41 N Pulaski St 21223			
14. FATHER'S NAME FIRST Reese MIDDLE McFadden LAST McFadden					15. MOTHER'S MAIDEN NAME FIRST Amelia MIDDLE McFadden LAST McFadden						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 251-26-8004		17. INFORMANT ADDRESS Nora McFadden 541 N. Pulaski St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-29-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-3-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem			23d. LOCATION CITY OR TOWN Balto. COUNTY MD. STATE MD.			
24. FUNERAL DIRECTOR NAME Chasa. Rice FSPA ADDRESS 1300 Eutaw Place						25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE 			

OFFICE OF THE
DIRECTOR



[Handwritten signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH	MIDDLE Edward	LAST MC GURRIN	2a. DATE OF DEATH MONTH DAY YEAR 12 06 83		2b. HOUR 2:50A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE, MARYLAND 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Painting
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2440 N. Charles St 21218
14. FATHER'S NAME FIRST MIDDLE LAST Anthony McGurrin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Rieley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Baltimore, Md 24 Anthony McGurrin 3410 Leverton Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer to the brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>small cell cancer</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/24, 19 83, to 12/06, 19 83, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/06, 19 83, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE Kathleen M. Fanning MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/6/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kathleen M. Fanning MD				22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD. 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		
24. FUNERAL DIRECTOR'S NAME Doppel Funeral Homes, Inc.				ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE Joan J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒ item 18 shows only injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Addison McKnight				12-26-83 2:35A.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 4 08		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) Lutheran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md				13b. COUNTY Balt. City		13c. STREET ADDRESS 2336 Reisterstown Road	
14. FATHER'S NAME FIRST MIDDLE LAST LAGREE Mc KNIGHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETHENA ANDERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 217-09-6110		17. INFORMANT ADDRESS JOSEPHINE Mc KNIGHT 2336 REISTERSTOWN RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/26, 19 83 to 12/26, 19 83, that (I) (we) last saw the deceased alive on 12/26, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				22c. DATE SIGNED death 2:35 pm			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Porcenen				22e. ADDRESS Lutheran hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-30-83		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT. CEMT.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME E.A. PHILLIPS 1721 - 27 N. MONROE ST. ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ARINTHIA B. McPHERSON				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1983			
3 SEX FEMALE				2b. HOUR 5:16pm			
4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR Nov. 28 1937		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 46		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist		12b. KIND OF BUSINESS OR INDUSTRY State Govn.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Carl McPherson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brent		13e. STREET ADDRESS 3504 Fairview Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-34-3806		17 INFORMANT ADDRESS Mary B. McPherson/3413 Fairview Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus 7100 DUE TO, OR AS A CONSEQUENCE OF (b) Systemic Vasculitis DUE TO, OR AS A CONSEQUENCE OF (c) Systemic Lupus Erythematosus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-1978 , 19 78 , to 12-26 , 19 83 , that (I) (we) lost saw the deceased alive on 12-26 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marsha J. Brown				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-28-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marsha J. Brown				22e. ADDRESS 844 N. Carey Street 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME MARSHALL W. JONES, JR. ADDRESS 4101 EDMONDSON AVE., BALTO., MD. 21229				25. DATE REC'D. BY REGISTRAR DEC 29 1983		25. REGISTRAR'S SIGNATURE John J. Carver	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Edith Ernestine McVey</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 25, 1983</i>			2b. HOUR <i>12:35 P.M.</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 15 89</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Rapp</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Harvey McVey Jr.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>None</i>		17. INFORMANT ADDRESS <i>304 Honnel Street 21224</i>			

18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardiovascular Disease - Cardiac Arrest**4292*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Chronic GI Disease - Colonic Cancer*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Atherosclerosis*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *g*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) sign this body after death.							
22b. SIGNATURE <i>Andrew Goldberg MD</i>				22c. DATE SIGNED <i>12/25/83</i>		22d. ADDRESS <i>Baltimore City Hospital</i>	
22e. PHYSICIAN'S NAME (PRINT) <i>ANDREW GOLDBERG MD</i>				22f. ADDRESS <i>E. Bachman Center 5200 Eastern Ave MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-29-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto. Co., Md. 21224</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler & Son Inc. 6224 Eastern Ave.</i>				25. DATE REC'D. BY REGISTRAR <i>DEC 29 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

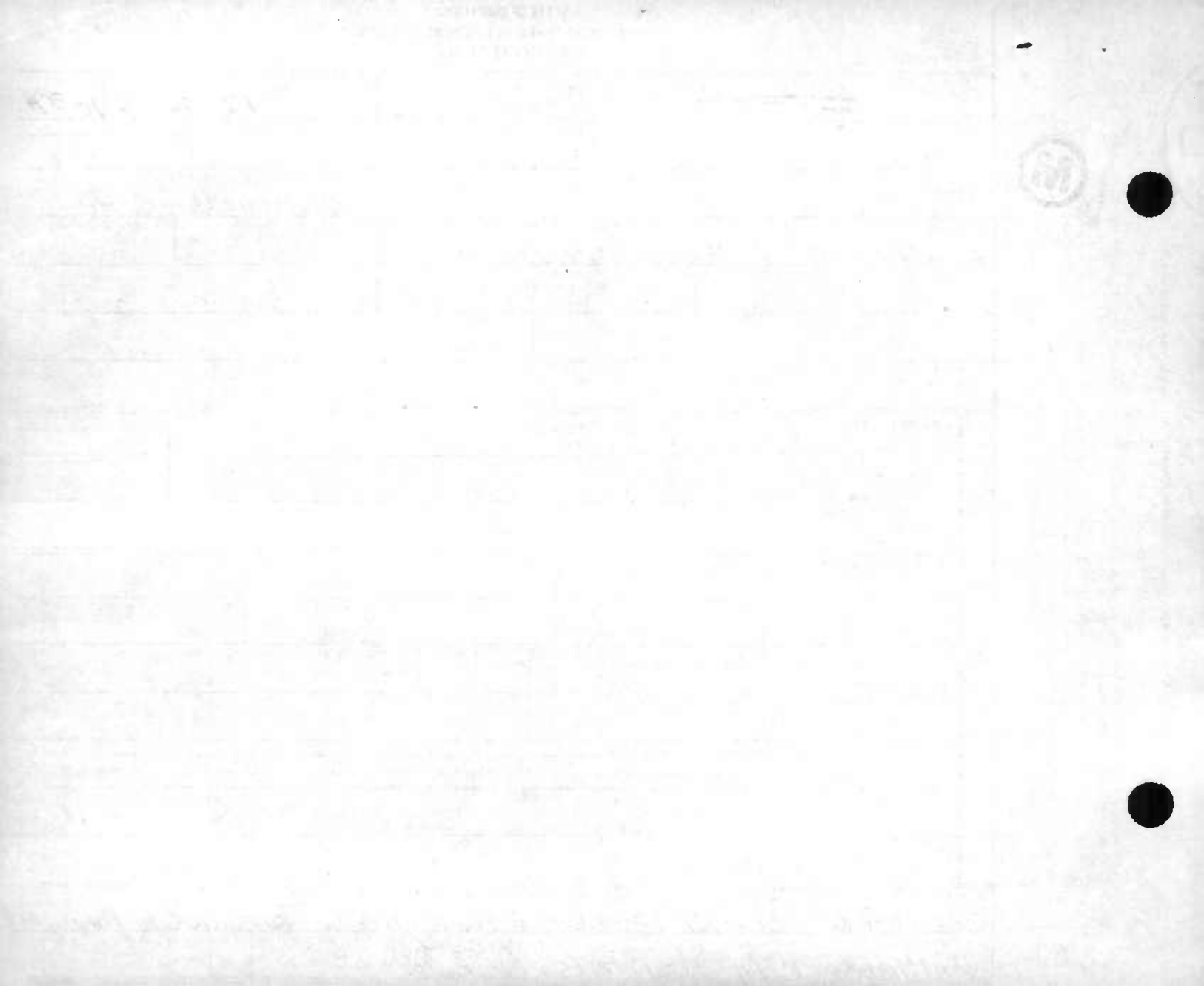
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harry Patricia Meadows, Jr.		2a. DATE OF DEATH MONTH DAY YEAR 12 24 83		2b. HOUR 10 30 AM
1. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12/24/83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 7
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harry James Meadows		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Ann Meadows		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Med. Rec.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine hemorrhage (Clinical signs)</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>perinatal asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
27b. SIGNATURE Evelyn B. Madde/c, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED 12/24/83
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Evelyn B. Madde/c		27e. ADDRESS Baltimore City Hospitals.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12-27-83	23c. NAME OF CEMETERY OR CREMATORY FRANKLIN SQUARE HOSPITAL	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	23e. DATE REC'D. BY REGISTRAR DEC 28 1983
24. FUNERAL DIRECTOR NAME ADDRESS Baltimore City Hospitals Ave. Baltimore				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		32710					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
James Meadows				12-30-83				11:55 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Black		7 8 06		77 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Alabama		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Provident Hospital				Laborer		Farm	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS			
John Meadows				Lucy James		2537 W. North Ave. 21216			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes				212-32-1562		Maggie Cooper 2537 W. North Ave. 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4860 CVA									
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumonia									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (if (this hospital) attended the deceased from 12-27-83 to 12-30-83, that (I) (we) last saw the deceased alive on 12-30-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Devadoss				DEGREE MD				22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
H. Devadoss				Provident Hospital.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/4/84		Chestnut Grove Cem		Street Harford Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gladden Kurtz III Jarrettsville, Md.						JAN 4 1984		John J. Conier	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MARGARET M. MEAGHER						20. DATE OF DEATH MONTH 12 DAY 09 YEAR 83		21. HOUR 8:20 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH AUG. DAY 24 , YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY 		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5000 WALTHER BLVD. 21214	
14. FATHER'S NAME FIRST PATRICK MIDDLE LAST BURNS				15. MOTHER'S MAIDEN NAME FIRST ANN MIDDLE LAST WARD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-10-5822		17. INFORMANT ADDRESS 21204 CHARLES MEAGHER JR. 26 STONERIDGE CT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) CHF, pulmedema - Apytrole. & DUE TO, OR AS A CONSEQUENCE OF cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY STATE 	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 				22e. ADDRESS GOOD SAMARITAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 12, 1983		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY STATE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL WIEDEFELD HOME				ADDRESS 6500 YORK RD. 21212		25a. DATE REC'D. BY REGISTRAR DEC 16 1983			
				25b. REGISTRAR'S SIGNATURE 					

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FOR 1- STATE REGISTRAR				Item 18b file 587 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 3.2 / 1 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William F. Meagher				2a. DATE OF DEATH MONTH DAY YEAR 12-13-83				2b. HOUR 10:45 AM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 7 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD				13b. COUNTY BALTO		13c. CITY OR TOWN Balto	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Meagher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Rainer				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II				16b. SOCIAL SECURITY NO. 218-07-3723		17. INFORMANT NAME ADDRESS Wm. F. Mayer (Meagher) 600 Albany St. Brunswick, Ga. -31520					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia Devositus ulcers DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cerebrovascular accident											
19a. DATE OF OPERATION 10-12-83				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Inability to eat				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from 8-8 , 19 83 , to 12-13 , 19 83 , that (b) I <input checked="" type="checkbox"/> saw the deceased alive on 12-13 , 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)											
22b. SIGNATURE Luis R. Ramos				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis R. Ramos				22e. ADDRESS 3001 S. Hanover St., Balto.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-25-83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.			
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206						25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE Sam J. Carver			



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John C. Miller Inc-2415 Cedar St.-21205
1-212-2415
New York, N.Y.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 83 32713									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BERNARD L MEINZINGER								DEC 25 83		10 05 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		BAVL		APR 22 26		57 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		US.				BALTIMORE MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		UNIVERSITY OF MARYLAND				BAR OWNER		BAR			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		100 S. BALDWIN ST		21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
BERNARD J. MEINZINGER		MARY W. KIESSLING									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
YES		219-10-8668		Mrs. Mary C. Bradley		3318 McElderry		21205			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY 0400 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
GAS GANGRENE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
DEC 24, 1983		GAS GANGRENE				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from DEC 24, 1983, to DEC 25, 1983, that (I) (we) last saw the deceased alive on DEC 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Yakov Friedman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED DEC 25, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
YAKOV FRIEDMAN		22 S. GREENE ST									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-27-83		OAKLAWN Cem.		Baltimore		MD.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE RECEIVED BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
Joseph N. Zannino Jr		243 S. CONKING		DEC 30 1983		John J. Glick					

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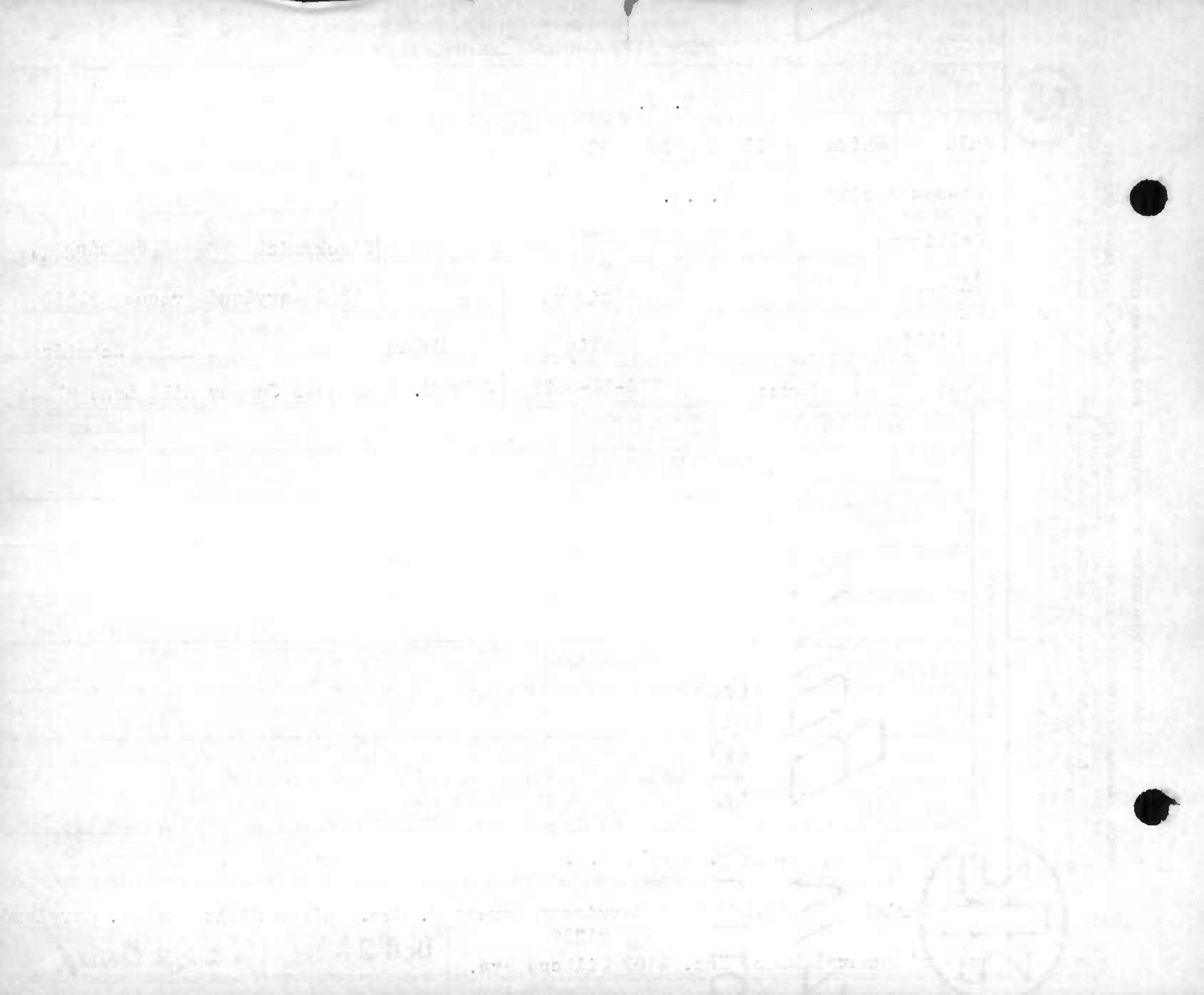
CHITTEPAW



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32714	
1. DECEASED NAME (TYPE OR PRINT) John V. W. Melia										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 12-23-83	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 4 YEAR 30		6. AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD 12-24-83		7b. HOUR 4LP		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 West 23rd Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Blacksmith		12b. KIND OF BUSINESS OR INDUSTRY Shoeing horse's			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2303 Maryland Avenue 21218			
14. FATHER'S NAME FIRST William MIDDLE Melia LAST Helen					15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Schmidt LAST Schmidt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. Korea		17. INFORMANT John T. Wolf		ADDRESS 4008 Jumper Hill Lane 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant						DATE SIGNED 12-25-83		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street, Baltimore, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest V. Cem.			23d. LOCATION CITY OR TOWN OWINGS Mills COUNTY Balto. STATE Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			ADDRESS 4107 Wilkens Ave.			25a. DATE RECD. BY REGISTRAR DEC 28 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD A. MELVIN					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1983			2b. HOUR 5:45AM	
3. SEX male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR April 27-1943		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Dept.		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2524 E. HOFFMAN St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Jim Melvin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Elliott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 6-9-67		17. INFORMANT ADDRESS Mrs. Lucille Melvin 2524 E. Hoffman St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTASIS CARCINOMA OF LIVER 1551 DUE TO, OR AS A CONSEQUENCE OF (b) CHOLANGIOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NO INJURY					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from NOV. 30, 1983, to DEC. 15, 1983, that (I) (we) lost saw the deceased alive on DEC. 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE GEORGE THOMAS M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Thomas				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Ctry		23d. LOCATION CITY OR TOWN COUNTY STATE Cedar Hill B.A.C. Md.			
24. FUNERAL DIRECTOR NAME Randolph J. Collick				ADDRESS 24316 Oliver St.		25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR WILLIAM HENRY MERGEHENN					CERTIFICATE OF DEATH REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Henry Mergehenn					2a. DATE OF DEATH MONTH DAY YEAR 12/4/83			2b. HOUR 4:35 PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-27-29		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Senior Vice Pres.		12b. KIND OF BUSINESS OR INDUSTRY Provident Bank of Md.	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2618 Litter Court 21043	
4. FATHER'S NAME FIRST MIDDLE Edward Mergehenn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Weaver		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 216-28-7993		17. INFORMANT 2618 Litter Court Barbara J. Mergehenn, Ellicott City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1729 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) melanoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1983, to 12/4, 1983, that (I) (we) lost saw the deceased alive on 12/4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas E Tafel						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2, 201	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E Tafel						22e. ADDRESS 22 S. Greene Street Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing any injury, or other traumatic event, the medical examiner will be notified at once.

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32717

1 DECEASED NAME (TYPE OR PRINT) LILY M MERRYMAN			2a DATE OF DEATH MONTH 12 DAY 3 YEAR 83 2b. HOUR 6:55 PM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH 8 DAY 10 YEAR 99	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Northern Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. CITY OR TOWN OF DEATH Baltimore		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY Balto		13c. CITY OR TOWN TOWSON	
14 FATHER'S NAME FIRST William MIDDLE Ross LAST Dixon		15 MOTHER'S MAIDEN NAME FIRST Rebecca MIDDLE Piper LAST Piper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-10-0927		17. INFORMANT ADDRESS 21030 James R. Pearce, 12206 Happy Hollow Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diffuse Atherosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 29, 19 83 to December 3, 19 83 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on December 3, 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE F. Wiegmann MD		DEGREE MD		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. WIEGMANN		22e. ADDRESS 8406 Harford Rd. / Baltimore, Md. 21234			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY Mays Chapel Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.		23e. DATE REC'D. BY REGISTRAR DEC 12 1983			
24. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 10 W. Padonia Rd.		25. REGISTRAR'S SIGNATURE John J. Connelley	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLOTTE METZGER			2a. DATE OF DEATH MONTH DAY YEAR 12 9 83			2b. HOUR 1:23P M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 30 07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE General Hosp. 10				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Cleaners	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST August Metzger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Wienecke				ADDRESS 47 Robinson Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-16-6356		17. INFORMANT Myrtle Gibbons (niece) Severna Pk. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metabolic Crises DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, massive									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Micronod. cirrhosis liver									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 8 19 83 to Dec 9 19 83 , that (I) (we) lost saw the deceased alive on Dec 9 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rhonda Richards M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rhonda Richards						22e. ADDRESS 3001 S. Hanover			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/12/83		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL HOME Schmunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE John J. Gail	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 7 1 9			
1. DECEASED NAME (TYPE OR PRINT) BEULAH MEYD				2a. DATE OF DEATH MONTH DAY YEAR 12 23 83			
3. SEX Female				7b. HOUR 845 AM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 86		7a. TIME 845 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clifford P. BURKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Beck		16. STREET ADDRESS / ZIP CODE 4012 Belwood Ave. 21206			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-14-7521		17. INFORMANT Randalstown, Md. 21133 A Donald J. Meyd, 3 Aventura Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) COPD & CHF 48 hrs DUE TO, OR AS A CONSEQUENCE OF (c) COPD & CHF yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ? Toxic ingestion							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 12/23/83	
22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 12/23 , 19 83 , that (I) (we) last saw the deceased alive on 12/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sander M. Cohen MD		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS UNION MEMORIAL HOSPITAL	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) SANDER M. COHEN M.D.		22g. DATE Dec. 28, 1983		22h. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22i. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25. DATE REC'D. BY REGISTRAR DEC 27 1983			
26. REGISTRAR'S SIGNATURE John J. Connel				27. REGISTRAR'S SIGNATURE John J. Connel			

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Handwritten notes and stamps, including "RECEIVED" and "MAILED" stamps, and various illegible text fragments.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Calvin Lorenzo Myers										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12-25-83	
3. SEX Male 4. RACE Black 5. DATE OF BIRTH (MONTH DAY YEAR) 1-10-1903 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD										2b. HOUR M	
10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 411 Dennison Street 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED 12b. KIND OF BUSINESS OR INDUSTRY										2c. DATE PRONOUNCED DEAD 12-25-83 2d. HOUR 9:36	
13a. STATE Md. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 411 N. Dennison St. 21216											
14. FATHER'S NAME FIRST Mejers MIDDLE L LAST Mejers 15. MOTHER'S MAIDEN NAME FIRST MARIA MIDDLE HUGHLETTE LAST HUGHLETTE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 216-03-7338A 17. INFORMANT Mr William Myers ADDRESS 3A Lemon Grove Ct Cockeysville Md 21030											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-25-83											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 12-28-83 23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM 23d. LOCATION CITY OR TOWN BALTIMORE COUNTY Md STATE											
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS ADDRESS 2222 W. North Ave. 25a. DATE REC'D. BY REGISTRAR DEC 28 1983 25b. REGISTRAR'S SIGNATURE John J. L...											

James Brown

1871-1872

21

RECEIVED

11th Nov 1871

1871-1872

1871

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.					
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA M. Mical						2a. DATE OF DEATH MONTH DAY YEAR 12-18-83				2b. HOUR 1:20 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH NOV 30, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balt. City Hsept (Mason F. Lord Building)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2000 Odell Ave		13f. ZIP CODE 21237	
14. FATHER'S NAME FIRST MIDDLE LAST Gotlieb						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-40-4410		17. INFORMANT ADDRESS Alfred Mical 8620 Schroeder Ave 21236							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 2989 DUE TO, OR AS A CONSEQUENCE OF (b) dementia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) suggestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from November 30, 1983 , to Dec 18, 1983 , that (I) (we) last saw the deceased alive on Dec 15, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John J. Carthens MD						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/18/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kilmer, Steven						22e. ADDRESS Mason F. Lord Bldg., Eastern Ave, Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 21, 83		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Oppe Funeral Homes, Inc.				ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE Sam E. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN EDWIN MIEGEL			2a. DATE OF DEATH MONTH DAY YEAR DEC 19 1983		2b. HOUR 7:03 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 16 28		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FISCAL OFFICER		12b. KIND OF BUSINESS OR INDUSTRY ST. OF MARYLAND
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 212-26-2139		17. INFORMANT ADDRESS LINDA JEAN MIEGEL 506 LAFAYETTE AVE., 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 8950 DUE TO, OR AS A CONSEQUENCE OF (b) SUSPECTED SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) BURNS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PNEUMONIA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS COUSAL IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. Nov 17 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 AND "OR" PART 2) STOVE EXPLOSION		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		
22a. I certify that (I) (this hospital) attended the deceased from Nov 17 , 19 83 , to DEC 19 , 19 83 , that (I) (we) lost saw the deceased alive on DEC 17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE H. Madden MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGH P. MADDOEN				22e. ADDRESS BALTIMORE CITY HOSPITAL		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-22-83		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR DEC 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connel

MEDICAL CERTIFICATION

APPROVED BY MEDICAL EXAMINER
CERTIFICATION APPROVED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARTHA MAY MIELKE			2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 83			2b. HOUR 5:30 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 32		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of MARYLAND				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. STREET ADDRESS 1429 Decatur Street 21230	
14. FATHER'S NAME FIRST Franklin MIDDLE Driggers LAST Loretta				15. MOTHER'S MAIDEN NAME FIRST Loretta MIDDLE Chisky LAST Chisky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-28-5743		17. INFORMANT ADDRESS Linda Mielke 1429 Decatur Street 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5183 IMMEDIATE CAUSE (a) Resp arrest / myelofibrosis DUE TO, OR AS A CONSEQUENCE OF (b) diffuse lung infarcts DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/25 , 19 83 , to 12/4 , 19 83 , that (I) (we) last saw the deceased alive on 12/4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Banerjee MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Banerjee MD		22e. ADDRESS U. of M Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

MEDICAL CERTIFICATION



CHARLES W.

50% COTTON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Milando			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1983			2b. HOUR 9:45 M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 26 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalesarium				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3026 E. Balto. Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Diulio			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-5744		17. INFORMANT ADDRESS Dominic Milando, 2239 Wilkens Ave. 21223					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4280 IMMEDIATE CAUSE (a) **Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Serious Dehydration

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 83 , to Dec 3 , 19 83 , that (I) (we) lost saw the deceased alive on Nov 1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard Bord MD				DEGREE MD		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Bord MD				22e. ADDRESS 9618 Bel Air Rd.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Joseph N. Zannino, 263 S. Conkling St. 21224				25a. DATE REC'D. BY REGISTRAR DEC 6 1983			
				25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M

(VR A 15 (4)) 9/74

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other authorized person must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Buoke MILLER					2a. DATE OF DEATH MONTH DAY YEAR 12 12 83			2b. HOUR 858 A M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 04 21 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED PHYSICIAN		12b. KIND OF BUSINESS OR INDUSTRY PHYSICIAN	
13a. STATE DEL.		13b. COUNTY New Castle		13c. CITY OR TOWN WILMINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4830 Kennett Pike 19807	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB BUCKE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linnie COULTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 091-40-4351B		17. INFORMANT Edgar R. Miller ADDRESS M.D. 4830 Kennett Pike Wilmington, Del. 19807					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LARGE INTRACEREBRAL HEMORRHAGE 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from 12-9- 19 83 , to 12-12 19 83 , that (I) <u>we</u> last saw the deceased alive on 12-12 19 83 , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE Peter H Cooke MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER H COOKE						22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Lower Brandywine Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington New Castle Delaware			
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Rd. Randallstown, Md. 21133						25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
ERIC B MILLER				12 06 83		5:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		July 23, 1976		7 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		CARROLL		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		21157	
Theodore		Lorraine		3606 Oxwood Court			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		LORRAINE Dowling		Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) 1919 Brainstem infiltration by tumor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Malignant glioma					
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from December 1, 1983, to December 6, 1983, that (I) (we) lost saw the deceased alive on December 6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Michael L. Graham, MD		MD		12/6/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Michael L. Graham, MD		Oncology 3-121, Johns Hopkins					
23a. BURIAL, CREMATION, REMOVAL (IF CIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		12-9-83		Lake View Cemetery		Sykesville, Carroll County, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Harry W. Haight		ADDRESS Sykesville, Md.		DEC 8 1983			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GEORGE NEWTON MILLER				2a. DATE OF DEATH MONTH DAY YEAR 12/26/1983			
3. SEX MALE				7b. HOUR 11:26aM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 6 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INTERIOR DECORATOR		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTORS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST NEWTON GEORGE MILLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA LAMBERT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216.09.1921		17. INFORMANT ADDRESS LORRAINE MACHEN 2483 FAIRWAY 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/23 19 83 to 12/26 19 83 , that (I) (we) last saw the deceased alive on 12/23 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph J. Cameron MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH J. CAMERON MD				22e. ADDRESS 1012 North 4th Rd, Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/1983		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD				25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE Joan J. Carver	

BP _____

CONFIDENTIAL



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gloria L Miller			2a. DATE OF DEATH MONTH DAY YEAR 12-04-83			2b. HOUR 6:35P M			
1. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 6 10 45		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Ctiy MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker		12b. KIND OF BUSINESS OR INDUSTRY Bank	
13a. STATE New Jersey			13b. COUNTY Gloster		13c. CITY OR TOWN Svedesborro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Fred Hollingsworth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna White			13e. STREET ADDRESS / ZIP CODE 212 Cherrywood Dr. 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 191-34-4169		17. INFORMANT		ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC ARREST**1922
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPOTENSION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CERVICAL CORD GLIOMA**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**10 MIN****8 HRS.****1 MONTH**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

ADULT RESPIRATORY DISTRESS SYNDROME, RENAL FAILURE, DISSEMINATED COAGULATION INTRAVASCULAR

19a. DATE OF OPERATION 11/2/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CERVICAL CORD GLIOMA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>Nov 1</u> , 19 <u>83</u> , to <u>DEC 4</u> , 19 <u>83</u> , that (1) <u>we</u> lost saw the deceased alive on <u>DEC 4</u> , 19 <u>83</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> <u>did</u> <u>not</u> view the body after death.							
22b. SIGNATURE Arthur N. Wang		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR N. WANG		22e. ADDRESS C/O JOHNS HOPKINS HOSPITAL DEPT OF NEUROSURGERY, BALTO. MD 21205					

23a. BURIAL, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Haven Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Chester Township Del Pa.	
24. FUNERAL DIRECTOR NAME Theodore Hawkins				25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	



C-381

12-04-51

REPLY

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CLARK

12-04-51

Reference to the above mentioned hospital number

the above mentioned hospital number

12-04-51

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	MIN.
LEE DANIEL MILLER						DEC. 26, 1983						6	56
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		WHITE		MARCH 18, 1922		61 YRS.			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.				BALTIMORE CITY					MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		SINAI HOSPITAL				EXECUTIVE			BOSTON METALS				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND				BALTIMORE		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		#21208 GREENLEA DR., BOX 3			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
BENJAMIN				BESSIE						ROME (SILVERSTEIN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
YES				WWI NAVY		MRS. RITA MILLER				GREENLEA DR., BOX 3 #21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable acute myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive arteriosclerotic heart disease</u> 14 foreign years. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>< 30 min</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>heart disease</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>many</u> 19 <u>year</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Peter Orzlan</u>				DEGREE				22c. DATE SIGNED					
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12-27-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
PETER ORZLAN, M.D.				600 REISTERSTOWN RD.				#21208					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE			
BURIAL				12-27-83		CHIZUK AMUNO-ARLINGTON		BALTIMORE		MD			
24. FUNERAL DIRECTOR				25. DATE RECEIVED BY REGISTRAR				REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS., INC.				DEC 30 1983				<u>John J. [Signature]</u>					
6010 REISTERSTOWN RD., BALTO., MD 21215													

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR MARY A. MILLER							
1. DECEASED NAME FIRST MIDDLE LAST MARY A. MILLER				2a. DATE OF DEATH MONTH DAY YEAR 12-22-83		2b. HOUR 6 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01-15-'31		6. AGE (IN YEARS LAST BIRTHDAY) 52 years YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Md. D of Trans.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN Riviera Bch.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 251 MEADOW RD. (21122)	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES F KEARNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE McGUIRE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
		16b. SOCIAL SECURITY NO. 218-26-8313		17. INFORMANT ADDRESS James Kearney 8300 Fairwood Dr. (21122)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CA of BREAST DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 12-16-1983 , to 12-22-1983 , that (we) lost saw the deceased alive on 12-22-1983 , and that in (an) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Chahur Moon MD				DEGREE MD		22c. DATE SIGNED 12/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOONDRA MAHESH				22e. ADDRESS 1028 RUSTLING OAKS DRIVE MILLERSVILLE MD 21108			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Baltimore, Md. 21225				25. DEC 27 1983		26. REGISTRAR'S SIGNATURE John J. Conner	
George J. Gonce F.H. 4001 Ritchie Hwy.							



NAME	MARY A	DATE	12-22-22
SEX	F	AGE	22
RESIDENCE	BALTIMORE	EDUCATION	HIGH SCHOOL
RELIGION	CATHOLIC	EMPLOYMENT	SEWING
REMARKS	MARRIED		

RECEIVED
FEB 1 1923



George F. Jones, 400 North 1st St., Baltimore, Md. 1122
JAN 2 1923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ELSIE ELSIE					2a. DATE OF DEATH MONTH DAY YEAR DEC 9, 83				
3. SEX FEMALE					2b. HOUR 930 P.M.				
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			7b. HOUR 930 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 DUMBARTON RD. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES McDUGALL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET G. COLLINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 213-48-1980		17. INFORMANT ADDRESS BETTY M. WINCHESTER 318 WEATHERBEE RD. 21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3989 CONGESTIVE HEART FAILURE IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) RHEUMATIC VALVULAR HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERTENSION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 3 DEC 19 83 , to 9 DEC 19 83 , that (1) was last saw the deceased alive on 9 DECEMBER 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death.									
22b. SIGNATURE Albert J Exner MD						22c. DATE SIGNED 9 December 1983		22d. DATE RECEIVED BY REGISTRAR DEC 14 1983	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT J. EXNER						22f. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 13, 1983			23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212									

10-3-31

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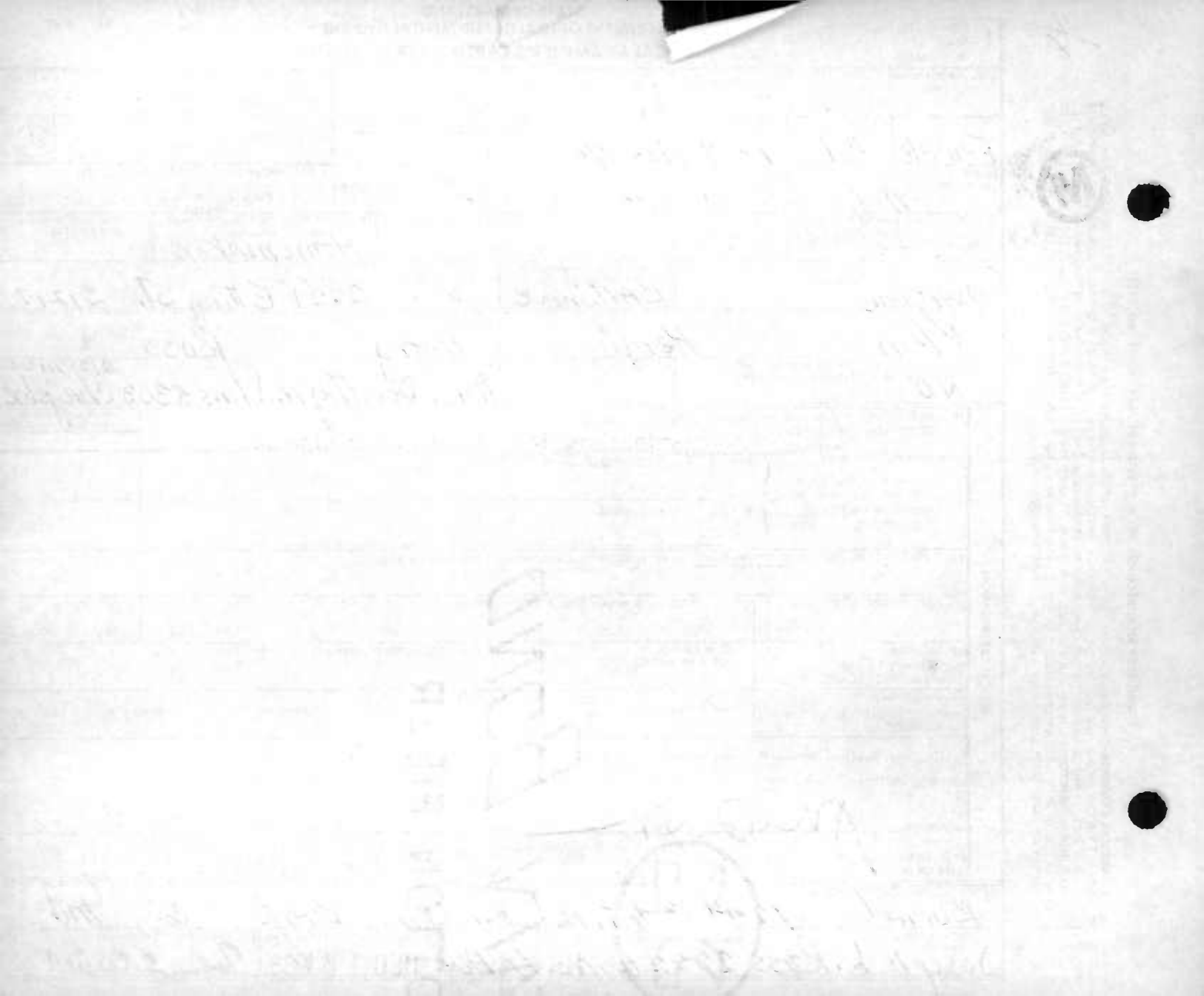
9-6-34

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE V. MILLS										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12 10 19 83	
3. SEX Female	4. RACE Col	5. DATE OF BIRTH MONTH DAY YEAR 1-7-1913	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 12 10 19 83	2b. HOUR 9:10		2d. HOUR 9:10			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2221 E. King St. 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Clem		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ross		16. INFORMANT Mrs. Dorothy H. Johns		ADDRESS 21207 Ave 5303 Chrysler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		16c. SOCIAL SECURITY NO.		16d. SOCIAL SECURITY NO.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) Assistant				DATE SIGNED 12-11-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SEE KEY) BURIAL		23b. DATE 12-14-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY Balto. Co. Md.					
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North Ave		25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Givier			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 32733			
1. DECEASED NAME (TYPE OR PRINT) FIRST GEORGE MIDDLE N. LAST MILLS				2a. DATE OF DEATH MONTH DAY YEAR 12 9 83			
3. SEX MALE				2b. HOUR 10 ¹⁰ P.M.			
4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 22 21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BAUTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS MILLS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly		13e. STREET ADDRESS / ZIP CODE 1307 S. HANOVER ST 21230			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-12-3006		17. INFORMANT ADDRESS Henrietta Easton 1307 S. Hanover St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1953 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) CA of Pericardium							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERICARDIAL ARTERIOSCLEROSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-14 19 83 , to 12-9 19 83 , that (I) (we) last saw the deceased alive on 12-9 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Reginald D. Riggsby MD DEGREE				22c. DATE SIGNED 12/9/83		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REGINALD D. RIGSBY, MD				22e. ADDRESS 3001 S. HANOVER ST. 21230			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/16/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Arundel Co, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 2 7 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM MINNIN			2a. DATE OF DEATH MONTH DAY YEAR 12 23 83			2b. HOUR 602 P.M.					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 05 09 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPER PAPER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY BALT CITY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 420 W. HIGHLAND AVENUE 21224		
14. FATHER'S NAME FIRST MIDDLE LAST ONORAN MINNIN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MATINSKI						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-9967		17. INFORMANT UNIVERSITY HOSPITAL			ADDRESS 225 GREENE ST BALTIMORE MD 21207		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 WEEKS

1729
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

METASTATIC MELANOMA

(c) DUE TO, OR AS A CONSEQUENCE OF

TREATED WITH BCNU

9 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

RENAL FAILURE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER, 19 1983</u> , to <u>12/23</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. N. OLIVE				DEGREE MD		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. N. OLIVE				22e. ADDRESS 40 UNIVERSITY OF MARYLAND CAMPUS LANE 225 GREENE ST. BALTIMORE MD 21207			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-83		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				7401 Belair Rd. ADDRESS Baltimore, Md. 21236		25a. DATE REC'D BY REGISTRAR DEC 28 1983	
				25b. REGISTRAR'S SIGNATURE John J. Connelley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or left blank, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ARCHIE G. MISTER					12		12	16	83	8:17 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White		May 26, 1922		61		MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Baltimore City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore	Baltimore (City Hospital)		Asbestos Worker		Union Local						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		-----		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1419 Patapsco St. Balto. Md. 21230			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
George				Fannie				Fowler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		W.W. 2		217-18-0902		Mrs. Margaret Mister, Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SQUAMOUS CELL CA W/ METASTASES (c) HYPERCALCEMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1983, to 12/16, 1983, that (I) (we) lost saw the deceased alive on 12/16, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
Eugene A. Melnick								12/16/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
EUGENE A. MELNICK		BALT CITY HOSP BALT MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Dec. 20, 1983		Cedar Hill Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.				DEC 20 1983		John J. Conner					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and calculations at the top of the page, including a small table with columns and rows of numbers and text.

Handwritten notes and calculations in the middle section, featuring a large, stylized 'C' or 'G' shape on the left side.

Handwritten notes and calculations at the bottom of the page, including a small table with columns and rows of numbers and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32736	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMMERETTA NMI MITCHELL				2a. DATE OF DEATH MONTH DAY YEAR 12 20 83	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 05 28 15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 1016 N. CAREY ST. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN McDUGALD (MC DONALD)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (LIDDE) (EVANS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 240-38-5156		17. INFORMANT ADDRESS Mable Butler 1016 N. Carey Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE NONLYMPHOCYTIC LEUKEMIA MULTIPLE MYELOMA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/20 19 83 to 12/20 19 83, that (I) (we) last saw the deceased alive on 12/20 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James M. Jones II M.D.		DEGREE		22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. JONES		22e. ADDRESS UNIV. OF MARYLAND CANCER CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.	
23d. LOCATION Baltimore, MD.		23e. DATE REC'D. BY REGISTRAR DEC 21 1983		23f. REGISTRAR'S SIGNATURE John J. Carver	
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 E North Avenue					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henrietta Whitfield Mitchell			2a. DATE OF DEATH MONTH 12 DAY 17 YEAR 83			2b. HOUR 6 32 A.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 5 DAY 9 YEAR 99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY Home			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Baltimore Md 13b. COUNTY Baltimore		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 2119 Braddish Ave, Baltimore		19. 2126			
20. FATHER'S NAME FIRST Clonon MIDDLE Whitfield LAST Whitfield		21. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Meldley							
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		23. SOCIAL SECURITY NO.		24. INFORMANT ADDRESS Christine Green 2119 Braddish Ave.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrest**

5188

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Pulmonary Insufficiency**

DUE TO, OR AS A CONSEQUENCE OF

(c) **P**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 17 , 19 83 , to Dec 17 , 19 83 , that (I) (we) last saw the deceased alive on Dec 17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harry E Lyndes		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry E Lyndes		22e. ADDRESS 3001 S Hanover St Balt					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE Md.	
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24. FUNERAL DIRECTOR Nutter and Sons Funeral Home, Inc.		2501 Gwynns Falls Pkwy, Balto. Md.		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

100

White House

Black



X

100

100



100% CASH

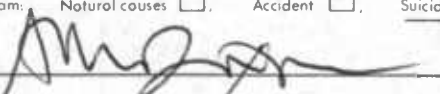
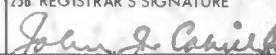
100% CASH

100% CASH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PAULINE MITCHELL						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12 9 19 83				2b. HOUR M 6:48 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 7 56		6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1728 Druid Hill Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1414 Franklin St. 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Gwantley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez Mitchell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 219-56-5761		17. INFORMANT ADDRESS Sylvia Wells 2404 Druid Hill Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 9570 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR ? P.M. 12-9- 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject jumped from window.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1728 Druid Hill Ave., Balto. City Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-10-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Landowne, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE 			

W. 70810-14 4. 20 1914
1012 70 30 2 4 20 1914



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JULIE NMN MOHR		DECEMBER 14, 1983		4:30AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
female	white	January 29, 1964	19	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Taiwan	USA		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		student		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	963 Noland Drive 21740	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Richard	Mary				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	213-90-0030	Mary Mohr, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>leukopenia/anemia</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>lupus nephritis/cerebritis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>83</u> , to <u>12/15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Mindy Shapiro MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Mindy Shapiro		Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
burial		Dec. 19, 1983	Rest Haven Cemetery	Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		DEC 19 1983		<u>[Signature]</u>	
MINNICH FUNERAL HOME					
415 E. Wilson Blvd., Hagerstown, Md. 21740					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and all data retained.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 3 3 2 7 4 0	
1. DECEASED NAME (TYPE OR PRINT) GLORIA Mae MOLINO					2a. DATE OF DEATH MONTH DAY YEAR 12 19 83			2b. HOUR MIN. 11 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 12 49		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE MD		13b. COUNTY BA		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6611 Bowman Hill Dr. 21207		
14. FATHER'S NAME FIRST MIDDLE LAST William Y POSPISIL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred BITTICK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-50-5399		17. INFORMANT Baltimore, MD 21207 John Molino 6611 Bowman Hill Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOTENSION 0389 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CHRONIC RENAL FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 12/19 1983 to 12/19 1983 , that (1) (we) lost saw the deceased alive on 12/19 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jon Schreiber, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/20/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon Schreiber				22e. ADDRESS 22 S. Greene St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY MacNabb Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD					
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc				25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. Conish					
26. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

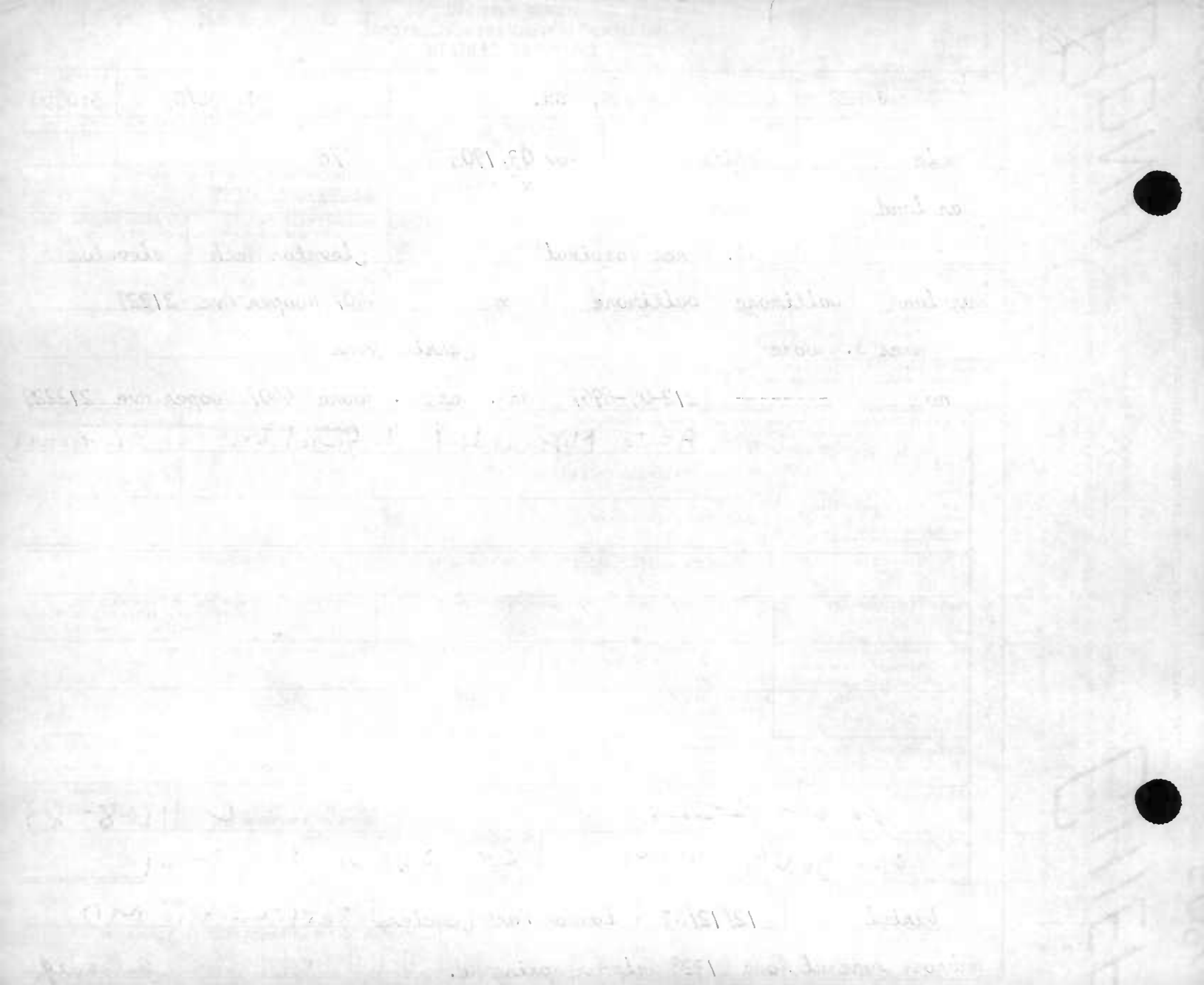
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES ARTHUR MOORE, SR.				2a. DATE OF DEATH MONTH DAY YEAR 12/08/83		2b. HOUR 3:05pm
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov 03, 1905		6. AGE [IN YEARS LAST BIRTHDAY] 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elevator Mech	12b. KIND OF BUSINESS OR INDUSTRY elevator	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4407 Hooper Ave 21229		
14. FATHER'S NAME FIRST MIDDLE LAST James S. Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie vans				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-09-8967		17. INFORMANT ADDRESS Mrs. Mary D. Moore 4407 Hooper Ave 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 hours
DUE TO, OR AS A CONSEQUENCE OF (b) _____						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature] DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-8-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DONG KIM				22e. ADDRESS St. Agnes Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 12/12/83	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR DEC 9 1983		
				25b. REGISTRAR'S SIGNATURE [Signature]		

BP

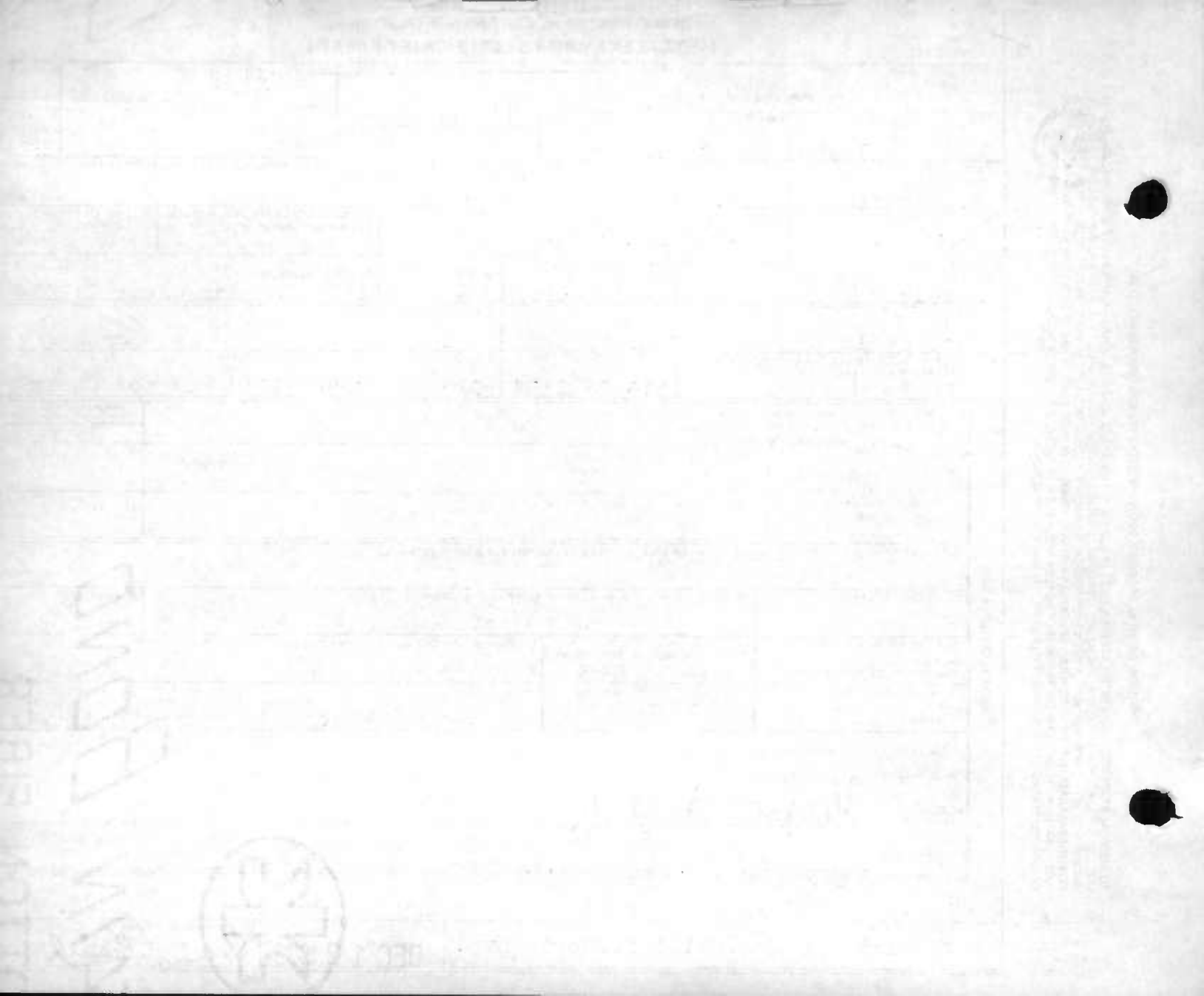


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

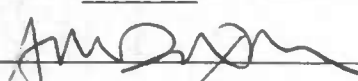

DHMH - 17
(VR A15 ME (5))
20M 4/82

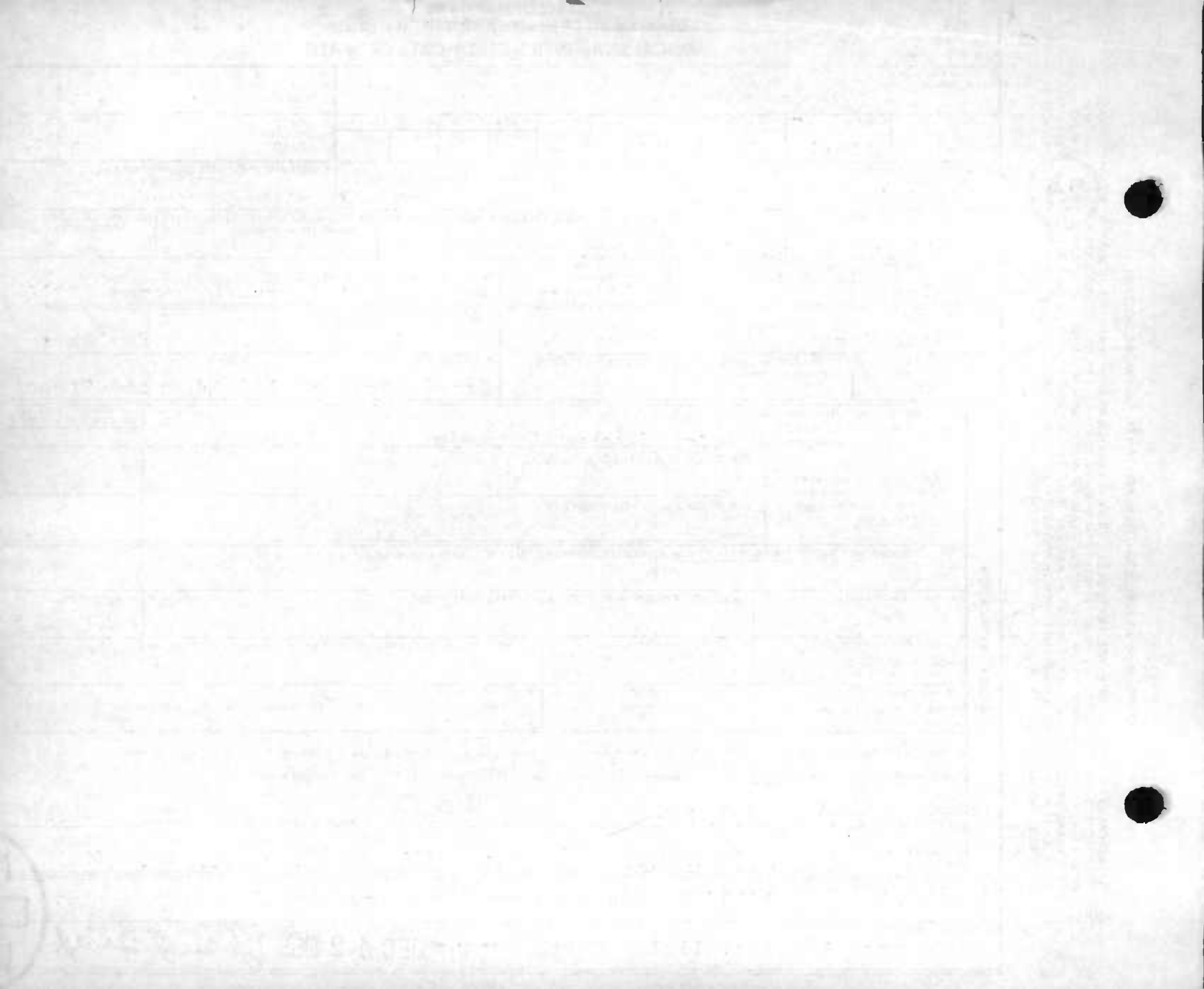
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES M. MOORE					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI. <input checked="" type="checkbox"/> 12-8-83					2b. HOUR M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 10 DAY 3 YEAR 58	6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 12-8-83					2d. HOUR 2:24
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1119 McAleer Court 21202				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore							
14. FATHER'S NAME FIRST Roosevelt MIDDLE LAST Brockington					15. MOTHER'S MAIDEN NAME FIRST Gladys MIDDLE LAST Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-78-5174		17. INFORMANT ADDRESS Gladys Moore 1119 McAleer Court						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of chest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:13 PM 12-8-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in a car		21f. LOCATION STREET 1100 Sarah Ann Street CITY OR TOWN Baltimore COUNTY Maryland STATE 					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/16/83		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. ADDRESS 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE John J. Canick			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32743	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT Lee MOORE						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 19 83		2b. HOUR 9:34			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 3 21 62 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 62		7c. DATE PRONOUNCED DEAD 12 8 19 83		7d. HOUR 9:34	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2409 Arunah Ave.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2409 Arunah Avenue 21216							
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Moore						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Faulkner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Nannie Freeman 125 Edgewood Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 12-8-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/13/83				23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery			
23d. LOCATION CITY OR TOWN Baltimore,				COUNTY Md.				STATE Md.			
24. FUNERAL DIRECTOR Wm C March F/H Inc.						25a. DATE REC'D. BY REGISTRAR DEC 12 1983					
ADDRESS 1101 E North Avenue						REGISTRAR'S SIGNATURE 					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles E. Baze More, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12/2/83			2b. HOUR 10:30 M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12/2/1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1037 Ashburton St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY 0	
13a. STATE Md			13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jeff Bazemore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Bazemore			13e. STREET ADDRESS 1037 Ashburton St. 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 0-0-0-0-0-0-0			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 0-0-0-0-0-0-0		17. INFORMANT ADDRESS Pearline Bazemore, 1037 Ashburton St. 21216				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cerebral Pulmonary Arrest**4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Previous CVA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

18BP Chronic Bronchitis

19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. --- 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ---			
22a. I certify that (I) (this hospital) attended the deceased from 10-2 , 19 80 , to 12-1 , 19 83 , that (I) (we) last saw the deceased alive on 12-1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Louis J. Domenici MD				DEGREE MD		22c. DATE SIGNED 12-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis J. Domenici MD				22e. ADDRESS 800 Bruden Ave Balt. 21216			

MEDICAL CERTIFICATION

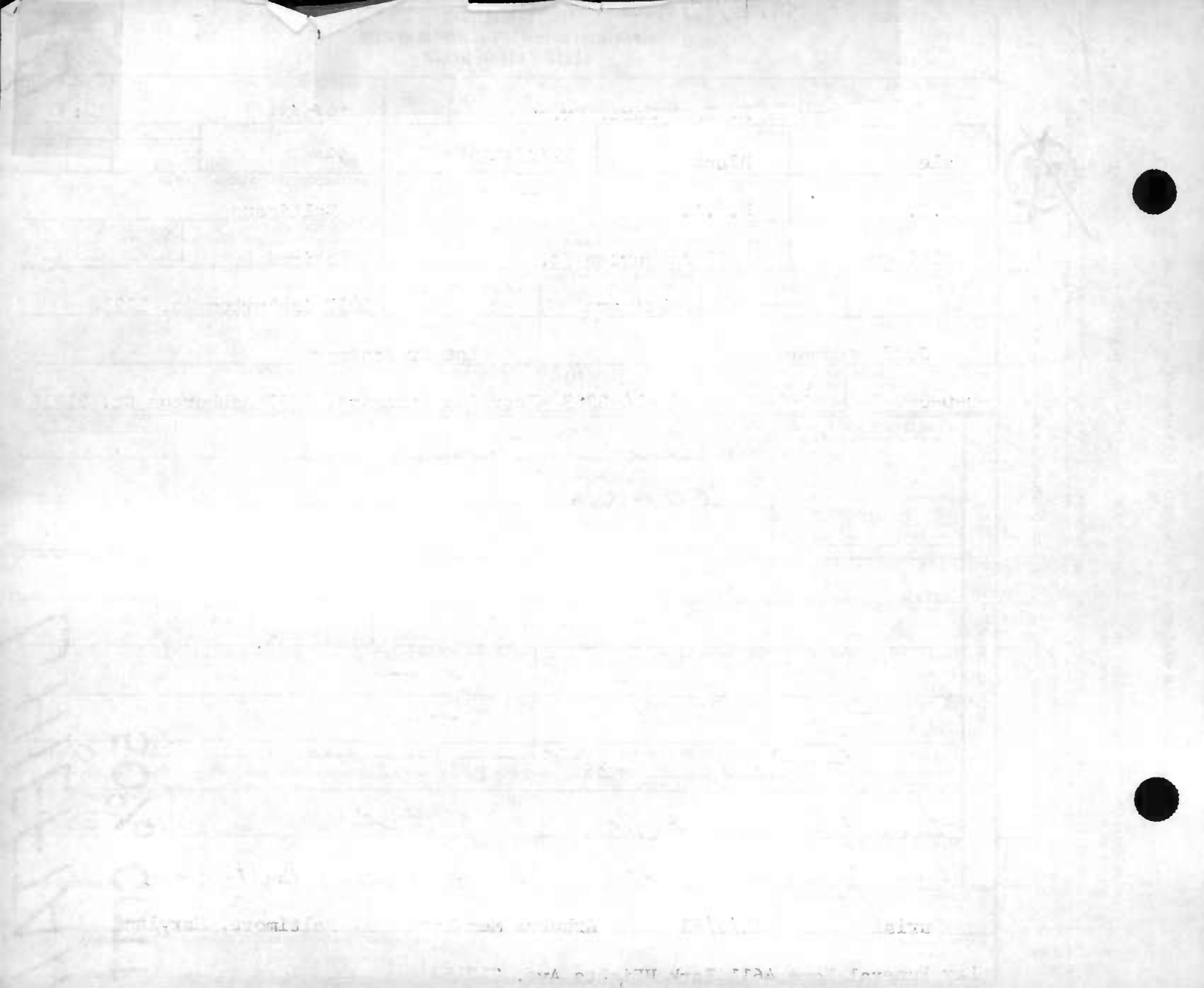
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave. 21215				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carroll	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST <i>Deena Morekas</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Dec 3, 1983</i>		2b. HOUR <i>M</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 14, 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS	IF UNDER 1 YEAR MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN. <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Greece</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3602 White Ave</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <i>Maryland</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>3602 White Ave</i>		21206	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Theodore Giannopoulos</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eurania</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-32-9579</i>		17. INFORMANT ADDRESS <i>Miss Nitsa Morekas Same As 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4149</i> IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 19 74</i> to <i>December 19 83</i> , that (I) (we) lost saw the deceased alive on <i>November 16 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.							
22b. SIGNATURE <i>E. Lignos</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12-3-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Evangelos Lignos M.D.</i>		22e. ADDRESS <i>211 Welford Rd Lutherville, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/5/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Leonard J Ruck Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 5 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Gwinn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

G#586 12/21/83 Items 14 & 15 FOR 1. STATE mtb REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 3 2 7 4 6 REG. NO.																								
1. DECEASED NAME (TYPE OR PRINT) LILLIAN S MORGAN															2a. DATE OF DEATH MONTH DAY YEAR 12 02 83															2b. HOUR 8:30 A.M.														
3. SEX FEMALE					4. RACE CAUCASIAN					5. DATE OF BIRTH MONTH DAY YEAR 04 04 83					6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.																													
10. CITY OR TOWN OF DEATH BALTIMORE CITY					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL															12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker										12b. KIND OF BUSINESS OR INDUSTRY														
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>															13e. STREET ADDRESS 600 Light St. 21230														
13a. STATE Md.					13b. COUNTY					13c. CITY OR TOWN Balto.																																		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. SHOCK										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Ann Mullen JULEN																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN										16b. SOCIAL SECURITY NO. 217-22-1854										17. INFORMANT ADDRESS 408 Old Orchard Rd. Ms. Mary Tremper Balto., Md. 21229																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5579 IMMEDIATE CAUSE (a) RESPIRATORY + CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ASCHEMIC Bowel Ischemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																												
19a. DATE OF OPERATION 11-27										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Aneurysm										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that (I) (this hospital) attended the deceased from 11-27 19 83, to 12-2 19 83, that (I) (we) last saw the deceased alive on 12-2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																												
22b. SIGNATURE W. Richards and															DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22c. DATE SIGNED 12-2-83																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Richards															22e. ADDRESS MERCY HOSP																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal										23b. DATE 12-2-83					23c. NAME OF CEMETERY OR CREMATORY Balto., Md.										23d. LOCATION CITY OR TOWN COUNTY STATE																			
24. FUNERAL DIRECTOR AME ANATOMICAL										ADDRESS BALTO., MD.										25a. DATE REC'D. BY REGISTRAR DEC 6 1983										REGISTRAR'S SIGNATURE John D. Smith														



CONFIDENTIAL

MEMORANDUM

DATE: 10-10-63

TO: THE DIRECTOR

FROM: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1. [illegible]

[illegible]

[illegible]

10-10-63

10-10-63

10-10-63

10-10-63

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A. LAST MORGAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 20, 1983		2b. HOUR A 12:01M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 3 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN CRISFIELD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Box 192 Chesapeake Ave. 21817	
14. FATHER'S NAME FIRST Charles MIDDLE M. LAST Hilditch		15. MOTHER'S MAIDEN NAME FIRST Nellie MIDDLE Reynolds LAST Hilditch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-01-6928		17. INFORMANT ADDRESS Bessie Weber 508 Taney Ave. Baltimore Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4149

IMMEDIATE CAUSE (a)

cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

refractory ventricular tachycardia

DUE TO, OR AS A CONSEQUENCE OF

(c)

severe chronic heart disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/10, 19 83, to 12/20, 19 83, that (I) (we) last saw the deceased alive on 12/20, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE M. Shulkin	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/20/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Threlkeld		22e. ADDRESS 601 N. WOLFE ST. - BALTO. MD. Johns Hopkins Hospital 21205	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 22/1983	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge	23d. LOCATION CITY OR TOWN COUNTY STATE CRISFIELD BALTIMORE MD.
24. FUNERAL DIRECTOR NAME Lucy C. Stealing		25a. DATE REC'D. BY REGISTRAR DEC 27 1983	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified at once.

DATE: 10/20/1910

TO: Mr. J. H. ...

FROM: Mr. J. H. ...

SUBJECT: ...

RE: ...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EUGENE MORRIS				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1983				2b. HOUR 6:15 PM			
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 8 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1328 Argyle Ave. Balto, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Morris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Bratton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-14.1376		17. INFORMANT ADDRESS FRANCES Morris 1328 Argyle Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis secondary to Kidney failure 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Intra Abdominal abscess (c) Widespread Pancreatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION December 12, 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pancreatic Carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that xx (this hospital) attended the deceased from December 10, 1983 to December 24, 1983 , that xx (we) lost the deceased alive on December 24, 1983 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above xx (we) (did) not view the body after death.											
22b. SIGNATURE W. King				DEGREE MD				22c. DATE SIGNED 12/26/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. King				22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-30-83		23c. NAME OF CEMETERY OR CREMATORY ARK, VA.		23d. LOCATION CITY OR TOWN COUNTY STATE ARK Gloucester VA.					
24. FUNERAL DIRECTOR NAME Nancy Wallace 2700 Edmonds Ave				25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE Sam J. Smith					

BP 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and carbon copies must be retained and forwarded.

STATE OF MARYLAND										
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) RAYMOND D. MORRIS					2a. DATE OF DEATH MONTH 12 DAY 17 YEAR 83					2b. HOUR 8:45 A.M.
1. SEX M		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 9 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caton Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Balto., Md. 21228 2660 Frederick Ave.		
14. FATHER'S NAME FIRST Enos MIDDLE LAST Morris				15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE M. LAST McCool				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-03-6180A
17. INFORMANT Grace Morris				17. ADDRESS 2660 Frederick Ave., Balto., Md.				17. PHONE NO. #21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST.										
4292 DUE TO, OR AS A CONSEQUENCE OF										
(b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE										
DUE TO, OR AS A CONSEQUENCE OF										
(c) 										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PNEUMONIA										
19a. DATE OF OPERATION NIL		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NIL				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NH 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NH		21f. LOCATION STREET NA		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-14- 19 83 , to 12-17- 19 83 , that (I) (we) last saw the deceased alive on 12-16- 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Surjit S. Julka				DEGREE MD				22c. DATE SIGNED 12/18/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURJIT S. JULKA				22e. ADDRESS CATON MANOR N. HOME						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY Woodbine Morgan Chap.		23d. LOCATION CITY OR TOWN Woodbine, COUNTY STATE Md.		23e. DATE RECEIVED BY REGISTRAR DEC 27 1983		
24. FUNERAL DIRECTOR NAME G. Truman Schwab		3512 Frederick Ave. ADDRESS # 21229		24. DATE RECEIVED BY REGISTRAR DEC 27 1983						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Henry Moses				12 14 83			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 23 24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1429 Kitmore Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST George Moses				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Moses			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes				16b. SOCIAL SECURITY NO. 227-18-6192		17. INFORMANT ADDRESS Shirley Moses 1429 Kitmore Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>October</u> , 19 <u>82</u> , to <u>December 14</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>November 22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Chang, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Chang, MD</u>				22e. ADDRESS 5601 Loch Raven Blvd. Suite 107			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA Owings Mills		23d. LOCATION CITY OR TOWN COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 15 1983 <u>John J. Carver</u>	

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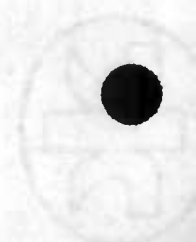
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				2b. HOUR
Edward Mosley					December 16, 1983				M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	Black	2 MONTH 18 DAY 04 YEAR		79 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VA	USA			Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Provident Hospital								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN					
MD				Baltimore		2300 Elsinore Ave. 21216			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
John Mosley					Laura Mosley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					213-14-0878		Denise Mosley 2308 Elsinore Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arrhythmia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal failure, Ca of Bladder</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28/73</u> to <u>12/14/83</u> , that (I) (we) last saw the deceased alive on <u>12/14/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>Rifat Abouy</u> MD			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Rifat Abouy			2 Hamell Rd						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			12/22/83		Cedar Hill Cem		Anne Arundel MD		
24. FUNERAL DIRECTOR NAME <u>Wm. C March</u> F/H <u>1101 E. North Ave.</u> ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					DEC 20 1983		<u>John J. Lamer</u>		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine Motyka			2a. DATE OF DEATH MONTH 12 DAY 18 YEAR 83			2b. HOUR 1045A		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 4 DAY 17 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) Poland		7b. CITIZEN OF WHAT COUNTRY? Poland		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Seamstress	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 355 South Drew Street 21224		
14. FATHER'S NAME FIRST George MIDDLE LAST Pondo				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-07-6647		17. INFORMANT ADDRESS Joseph Motyka 355 S. Drew St. 21224				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 5860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic heart disease, CHF DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 83 , to 12/18 , 19 83 , that (I) (we) last saw the deceased alive on 12/18 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death, so state.)								
22b. SIGNATURE Richard L. Linthicum M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-18-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L. LINTHICUM				22e. ADDRESS MERCY HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-83		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.		
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 6224 Eastern Ave.		25. DATE REC'D. BY REGISTRAR (SIGNATURE) DEC 20 1983		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. MOULTRIE			2a. DATE OF DEATH MONTH DAY YEAR 12/10/83		2b. HOUR 12 45 PM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12/21/00	6. AGE (IN YEARS LAST BIRTHDAY) 82		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. 10 11 12 45
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALTO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John C. Moultrie			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza J.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-5038	17. INFORMANT ADDRESS Susan Gibbs 1905 Winford Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7070 CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Previous Cardiac Arrest, Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia / Sepsis / Decubitus Ulcers					
19a. DATE OF OPERATION 12/11/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Decubitus Ulcers		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/29, 1983, to 12/10, 1983, that (I) (we) lost saw the deceased alive on 12/10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marc Siegelbaum			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC SIEGELBAUM			22e. ADDRESS Sinai Hosp. of Balto., 21215		
23a. BURIAL, CREMATION, REMOVAL (STATE) BURIAL	23b. DATE 12/14/83	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Georgetown, S.C.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue			25a. DATE REC'D. BY REGISTRAR DEC 12 1983		
			25b. REGISTRAR'S SIGNATURE John J. Conish		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first part of the document discusses the importance of maintaining accurate records of all activities. It states that this is essential for ensuring the integrity of the information and for providing a clear and concise summary of the work done.

2. The second part of the document describes the various methods used to collect and analyze data. It includes a detailed description of the procedures followed, as well as the results of the analysis.

3. The third part of the document discusses the implications of the findings and the steps that will be taken to address any issues that have been identified. It also includes a list of recommendations for future work.

4. The fourth part of the document provides a summary of the key points discussed in the previous sections. It also includes a list of references and a list of appendices.

5. The fifth part of the document is a list of the names of the individuals who have contributed to the work. It includes the names of the principal investigators, as well as the names of the other staff members who have been involved in the project.

6. The sixth part of the document is a list of the names of the organizations that have provided support for the work. It includes the names of the funding agencies, as well as the names of the other organizations that have provided resources.

7. The seventh part of the document is a list of the names of the individuals who have reviewed the work. It includes the names of the reviewers, as well as the names of the individuals who have provided feedback.

8. The eighth part of the document is a list of the names of the individuals who have approved the work. It includes the names of the individuals who have signed off on the work, as well as the names of the individuals who have provided their approval.

9. The ninth part of the document is a list of the names of the individuals who have been involved in the work. It includes the names of the individuals who have been involved in the planning, execution, and review of the work.

10. The tenth part of the document is a list of the names of the individuals who have been involved in the work. It includes the names of the individuals who have been involved in the planning, execution, and review of the work.

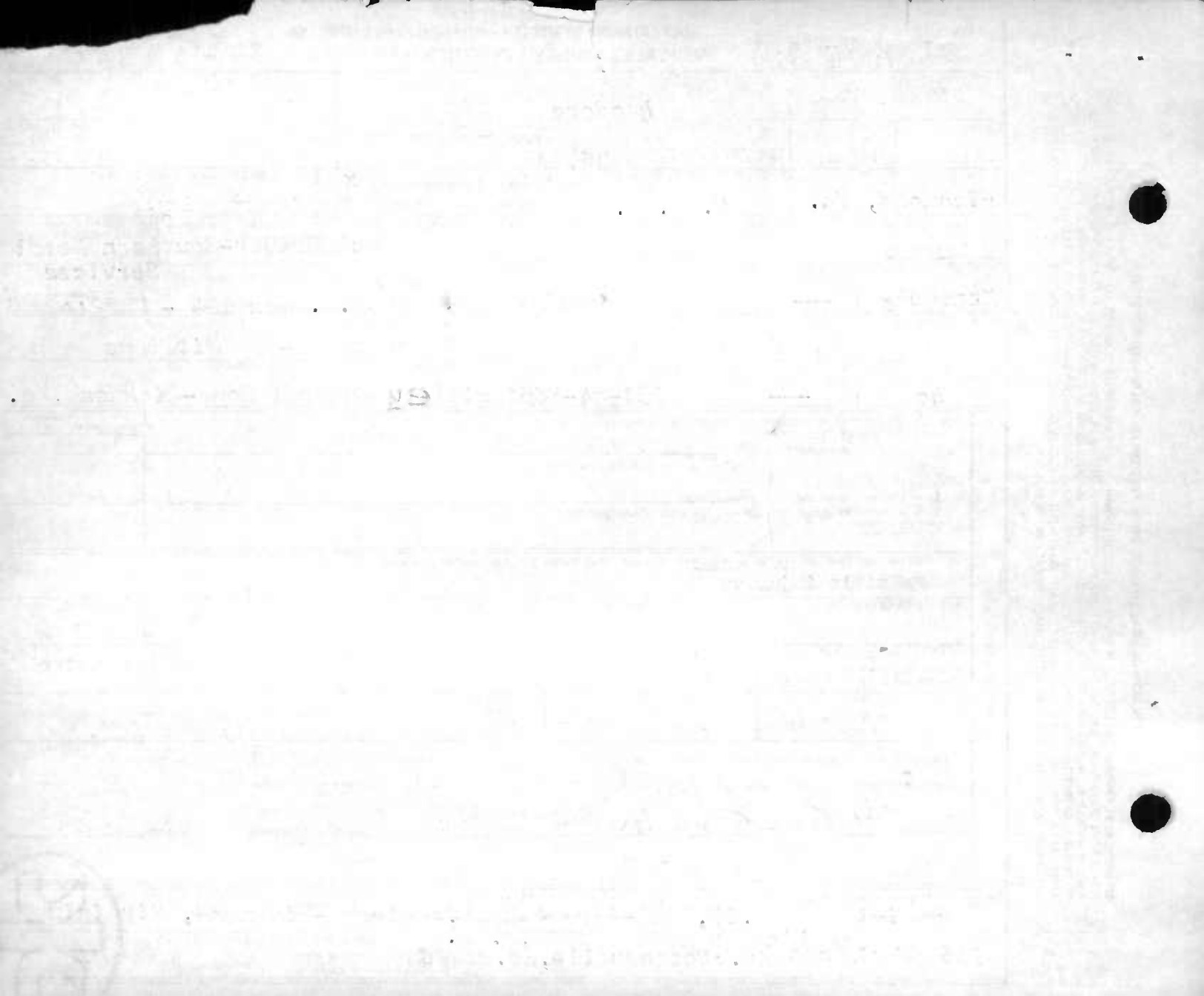


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CLASS. & EXTENSION

SECRET
NO. 100-100000
CLASS. & EXTENSION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32755	
1. DECEASED NAME (TYPE OR PRINT) John Theodore Mowbray						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-23 1983		2b. HOUR M 6:25 P. M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 01/09/57	6. AGE (IN YEARS) LAST BIRTHDAY 26 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 12-23 1983					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Richmond, Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1700 blk. McComas Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver-Southern Metal Services		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Kentucky		13b. COUNTY ---	13c. CITY OR TOWN Richmond	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1513 Columbia Street P.O. Box 124 - 40437-23224						
14. FATHER'S NAME Curtis Emmett Mowbray				15. MOTHER'S MAIDEN NAME Elizabeth Frances Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 231-84-8851		17. INFORMANT ADDRESS Bliley Funeral Home-Richmond, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Drowning 8150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple injuries											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 6:10 P.M. 12-23 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) which overturned into water after driver in auto/fixed object impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street Water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1700 blk. McComas St., Baltimore, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-24-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial Gardens				23d. LOCATION Good Land Co. COUNTY, Virginia			
24. FUNERAL DIRECTOR Sterling Funeral Estate, P. A. 736 Edmondson Av., Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Gault					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOYLER
2b. DATE KNOWN OF DEATH ☐ MONTH ☐ DAY ☐ YEAR 12 24 19 83 2d HOUR M

3. SEX Male 4. RACE Black 5. DATE OF BIRTH (MONTH DAY YEAR) 12 31 27 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 2c. DATE PRONOUNCED DEAD 12 26 19 83 2d HOUR P M 12:44

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia 9. CITIZEN OF WHAT COUNTRY? U.S.A. 10. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD

12. CITY OR TOWN OF DEATH Baltimore 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 910 Pennsylvania Avenue 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 15. KIND OF BUSINESS OR INDUSTRY

16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland 17b. COUNTY 17c. CITY OR TOWN Baltimore 17d. INSIDE CITY LIMITS? YES ☒ NO ☐ 17e. STREET ADDRESS 910 Pennsylvania Ave. 21201

18. FATHER'S NAME FIRST MIDDLE LAST 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Moyler

20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 20b. SOCIAL SECURITY NO. 220-12-5927 21. INFORMANT ADDRESS Carolyn Bishop 444 E. 41st St. Patterson, NJ

22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 4279 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

23a. DATE OF OPERATION 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 24. AUTOPSY? YES ☒ NO ☐

25a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

26a. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 26b. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) 26c. LOCATION STREET CITY OR TOWN COUNTY STATE

27. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ and in my opinion

28. ACTUAL SIGNATURE Thomas D. Smith, M.D. TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER DATE SIGNED 12/27/83

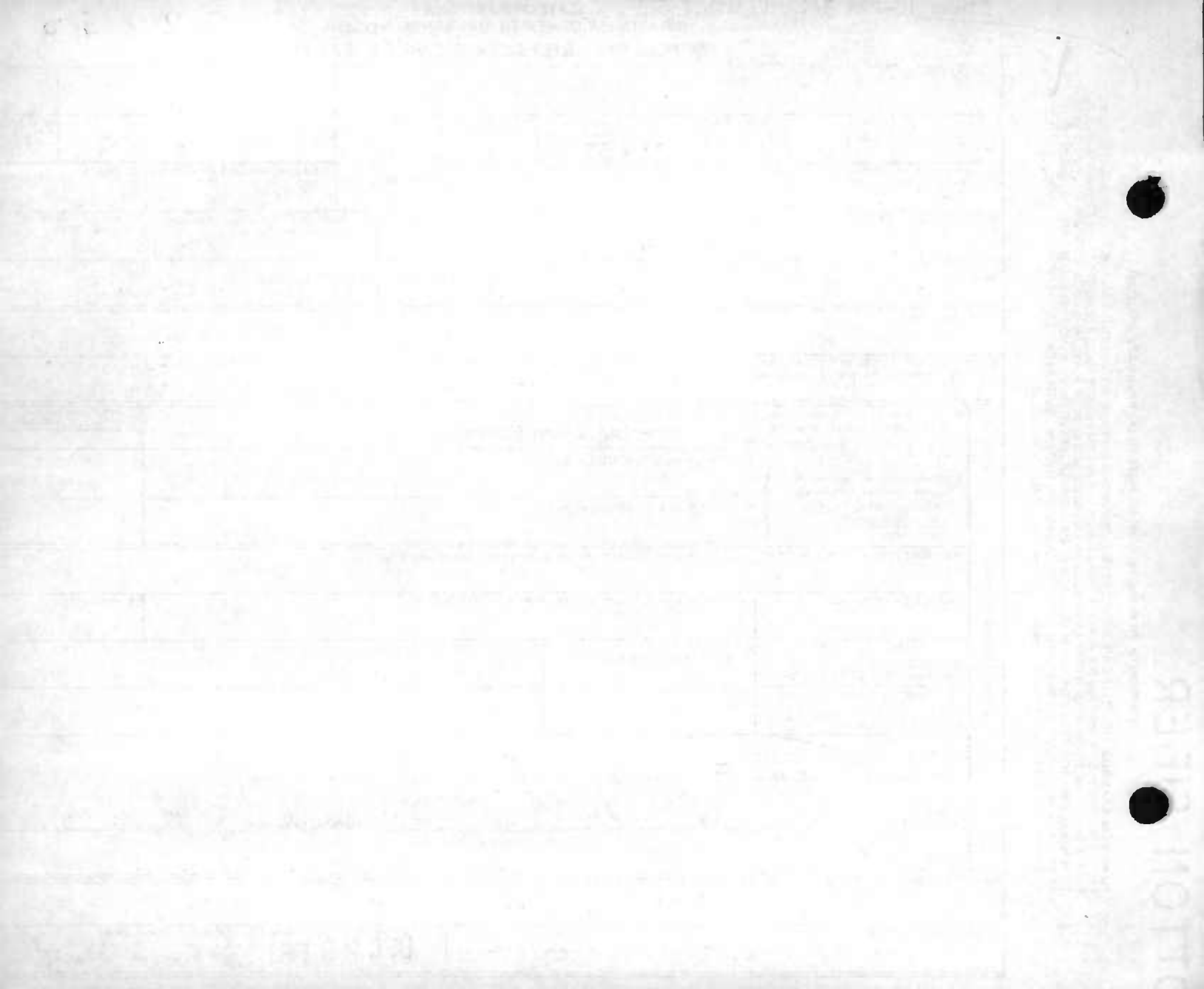
29. EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn st. Balto., MD.

30. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL 31. DATE 12/30/83 32. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery 33. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.

34. FUNERAL DIRECTOR NAME Wm March F/H Inc. ADDRESS 1101 E North Avenue 35. DATE REC'D. BY REGISTRAR DEC 29 1983 36. REGISTRAR'S SIGNATURE John J. Connel

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NEARLY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH	
			Dr. ARTHUR CHARLES MUHLBACH		12 27 83 4:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)
Male		White		May 1, 1894		89 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Balto., Maryland		USA				BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
BALTIMORE		THE UNION MEMORIAL HOSPITAL				Dr. Dental Surg.
12b. KIND OF BUSINESS OR INDUSTRY		Retired				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE		
John Louis Muhlbach		Christine Metzger		201 Woodlawn Road - 21210		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes		W.W. I 213-38-6095A		Mrs. Emma Kloppel Muhlbach-201 Woodlawn Rd. - 21210		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Massive pulmonary embolus</u> <u>4151</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>dissecting thoracic aneurysm, fever of unknown origin, Salmonella sepsis Hx</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>December 7, 1983</u> to <u>December 27, 1983</u> , that (I) (we) lost <u>the deceased</u> on <u>December 27, 1983</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
David M. Yousem MD				12/27/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
David M. Yousem		Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)
Burial		Dec. 30, 1983		Druid Ridge Cemetery		Balto. County, Md.-21208
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Henry Sander & Sons, Inc., Balto., Md.-21213				DEC 29 1983		John J. Connel

BP

12-11-54

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Mr. Dwight D. Eisenhower

White House

Washington, D.C.

Dear Mr. President:

I am very pleased to hear that you are well and hope that you are enjoying the holidays.

I am sure that you will have a very successful and happy New Year.

I am sure that you will have a very successful and happy New Year.

I am sure that you will have a very successful and happy New Year.

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I am sure that you will have a very successful and happy New Year.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	MIN.
EDNA		Hall	MULLER		12/10/83					130	P
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	White	May 25, 1895		88		YRS.		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA			BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE	UNION MEMORIAL HOSPITAL			Homemaker			Own Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD			Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		600 Light St., 21230					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Edward Hall				Annie Ringler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		212 50 5299		Frank E. Potterfield, Jr., Balto., MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>											years
4292 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <i>Congestive heart failure</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (the hospital) attended the deceased from 12/19, 1983, to 12/10, 1983, that I (we) lost the deceased <i>the deceased</i> on 12/10, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, and I did not view the body after death, so state.)											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Barbara M. Rock				MD				12/10/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Barbara M. Rock, M.D.				Union Memorial Hospital Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		12/13/83		Dulaney Valley		Balto. County,				MD	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						DEC 13 1983		John J. Lewis			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Henry W. Jenkins & Sons Co.

State, N.Y., 1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a post-mortem examination required.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MABEL C. MURPHY					2a. DATE OF DEATH MONTH DAY YEAR 12/27/83			2b. HOUR 10:20 am			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 29 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COUNTER CLERK		12b. KIND OF BUSINESS OR INDUSTRY DELICATESSEN			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1907 LETITIA AVENUE, 21230			
14. FATHER'S NAME FIRST MIDDLE LAST FLETCHER DAWSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH ELLEN LEE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214-22-5068		17. INFORMANT ADDRESS HELEN E. BOYCE 1907 LETITIA AVENUE, 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute hemorrhage, tracheobronchial tree 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhagic abscess, R lung + DIC (c) Pulmonary emphysema + fibrosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/23 19 83 to 12/27 19 83 , that (I) (we) last saw the deceased alive on 12/27 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William J. Hicken					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. HICKEN					22e. ADDRESS St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-30-83		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE CHASE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.					25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Connel				

BP.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Bertha BAER</u> <u>Myers</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12/2/83</u>			2b. HOUR <u>12:55 AM</u>				
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>9 04 08</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. PLACE OF BIRTH <u>MARYLAND</u> <u>XXXXXX</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.				
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SINAI HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		
13a. STATE <u>MD</u>			13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>XXXXXX</u>		13d. INSIDE CITY LIMITS? <u>NO</u>		13e. STREET ADDRESS <u>3204 Old Post Dr. Apt 8</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>MORRIS</u> <u>BAER</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ANNA</u> <u>TREGER</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>203-20-6928</u> <u>213-16-9928-D4</u>			17. INFORMANT <u>MR. L. CAROL MYERS</u> <u>3204 OLD POST DR., APT. 8 #21208</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abd Sepsis? Pulm Embolus?</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Regional Enteritis, Para Supraventricular Tachycardia, Dementia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>83</u> , to <u>12/2</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/1/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Marc Paul</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/2/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARC PAUL</u>			22e. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>12-4-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW CONG.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE</u> MD			
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., INC.</u> NAME ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u>					25a. DATE REC'D. BY REGISTRAR <u>DEC 6 1983</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Laniel</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar/Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

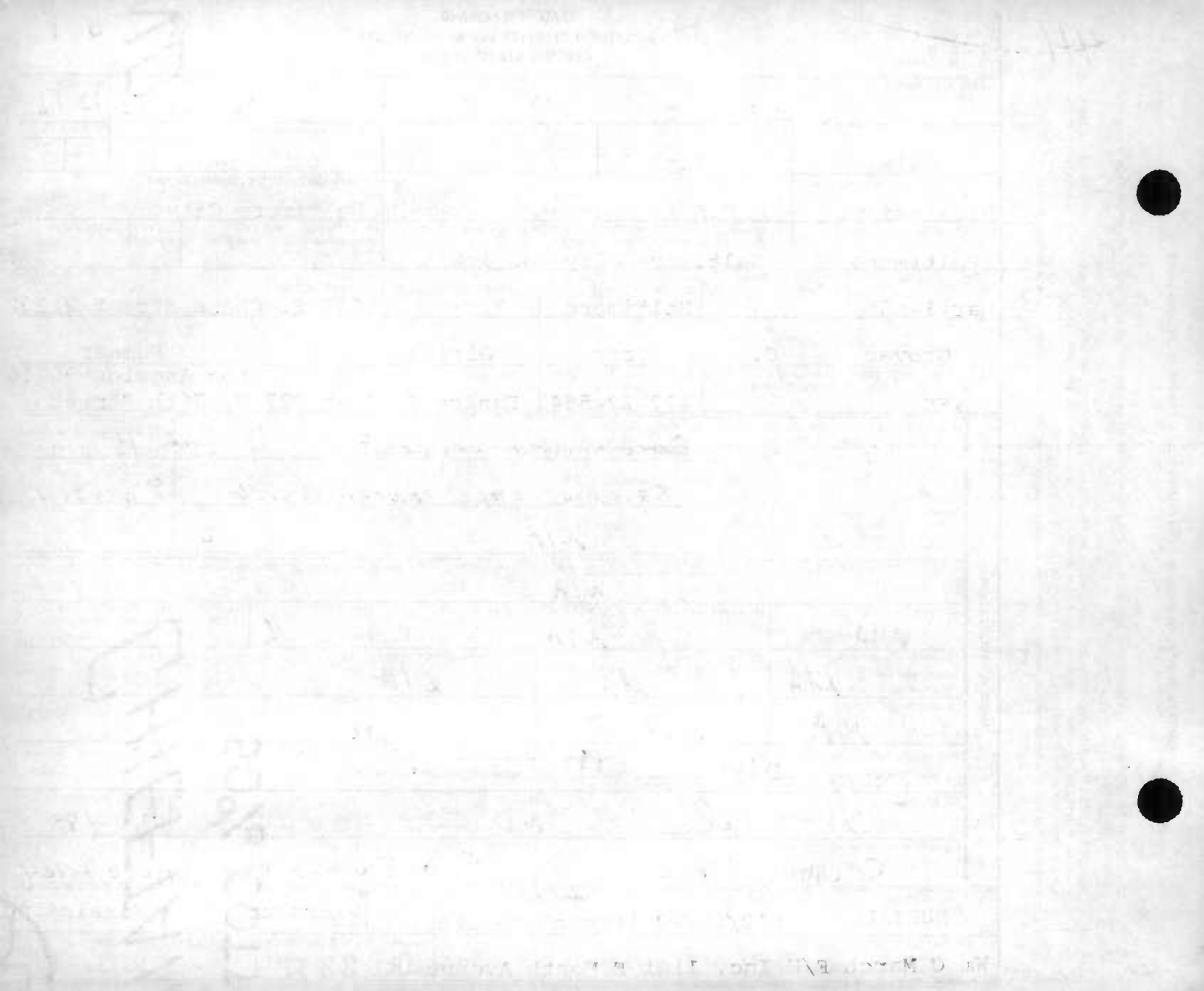
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified ~~at once~~.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83332761							
FOR 1 - STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FRITZLE C. MYERS					2a. DATE OF DEATH MONTH DAY YEAR 12 22 83			2b. HOUR 12 15 A.M.									
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 28 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1224 E. Chase Street 21202									
14. FATHER'S NAME FIRST MIDDLE LAST Grover C. Myers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Girlie Summer												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 427-22-5643		17. INFORMANT Eunice K. Cash 937 W. 76th Street				ADDRESS Los Angeles 90044									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SQUAMOUS CELL CANCER LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>N/A</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 8 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION N/A												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A													
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>83</u> , to <u>12/22</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Stuart Katz					DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STUART KATZ					22e. ADDRESS 4940 Eastern Ave BALTO 21224												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/83		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery			23d. LOCATION Vicksburg, Mississippi		23e. COUNTY								
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. Canine										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HELEN G. NASH					2a. DATE OF DEATH MONTH DECEMBER DAY 12 YEAR 83		2b. HOUR 5 40 P.M.				
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH OCTOBER DAY 14 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 302 WEST 28th ST. 21218			
14. FATHER'S NAME FIRST PERRY MIDDLE LAST BROOKS				15. MOTHER'S MAIDEN NAME FIRST ISABELLA MIDDLE LAST GRAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. A 215-32-2961		17. INFORMANT DOROTHY T. NASH 325 WEST 28 STREET 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY failure 4280 DUE TO, OR AS A CONSEQUENCE OF: (b) heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF: (c) heart dz - chronic afib										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): ? Bowel infarction, L BKA 20 to embolus											
19a. DATE OF OPERATION 11/30/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of foot				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 		CITY OR TOWN 		COUNTY 		STATE 	
22a. I certify that (I) (this hospital) attended the deceased from 12-7 , 19 83 , to 12-6 , 19 83 , that (I) (we) lost saw the deceased alive on 12-6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David S. Dunn MD				DEGREE				22c. DATE SIGNED 12-6-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. DUNN MD				22e. ADDRESS 201 E. University Pkwy							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE 					
24. FUNERAL DIRECTOR MARSHALL W. JONES, JR. NAME 4101 EDMONDSON AVENUE, BALTO., Md.						25a. DATE REC'D. BY REGISTRAR DEC 8 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

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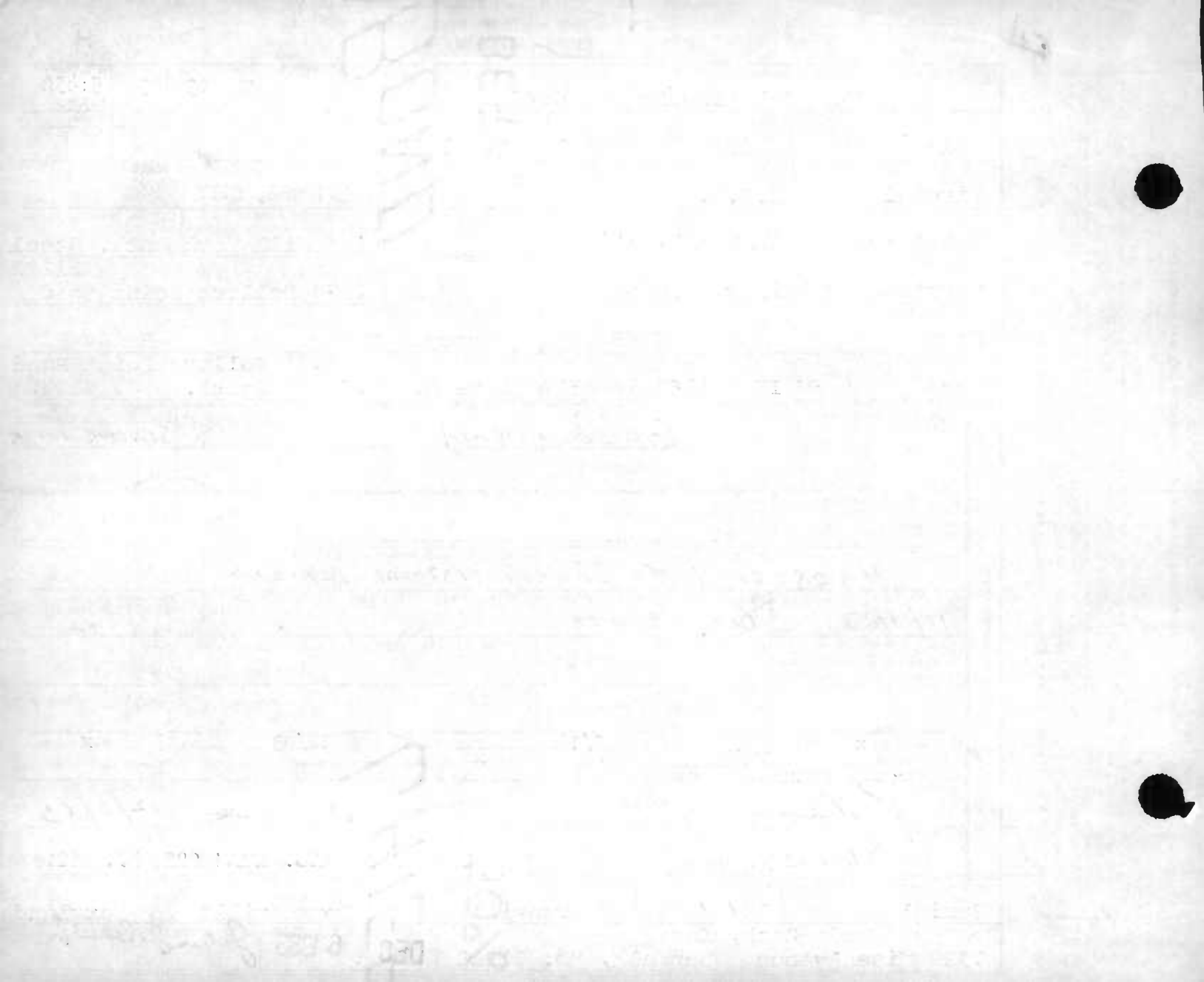
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

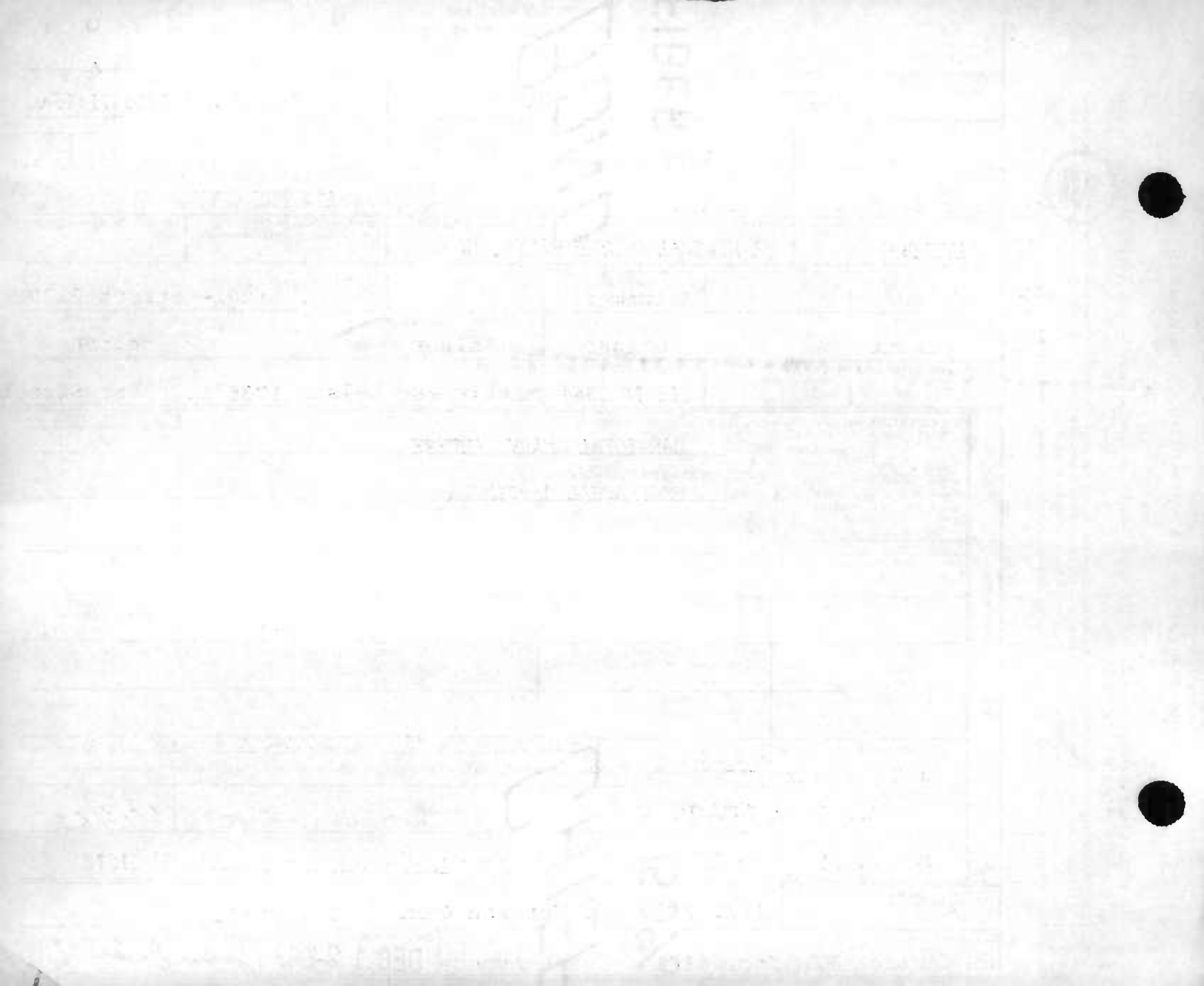
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Vincent Neff						2a. DATE OF DEATH MONTH DAY YEAR 12 03 83		2b. HOUR 5:45A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, LOCH RAVEN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Mill Work		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2970 Sollers Point Road 21222			
14. FATHER'S NAME FIRST MIDDLE LAST John Neff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tracy Reidy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 167-14-4314		17. INFORMANT 2970 Sollers Point Road Balto., MD. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) GLIOBLASTOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. HISTORY OF UPPER GASTROINTESTINAL BLEEDING.											
19a. DATE OF OPERATION 10/14/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOT WHITE AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED NOT WHITE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/16 , 19 83 , to 12/03 , 19 83 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/03 , 19 83 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE P. Kennedy				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/3/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. KENNEDY, M.D.				22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/1983		23c. NAME OF CEMETERY OR CREMATORY Crowsville		23d. LOCATION CITY OR TOWN COUNTY STATE Crowsville Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR DEC 6 1983					



1. DECEASED NAME (TYPE OR PRINT) SAMUEL N. NELSON						2a. DATE OF DEATH MONTH DAY YEAR December 8 1983						2b. HOUR 11:15a.m.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 14 07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 416 E. Biddle Street 21202			
14. FATHER'S NAME FIRST MIDDLE LAST Genetta Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Walter Nelson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 10 2364		17. INFORMANT ADDRESS Mattie Mae Nelson 1736 E. Chase Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1509 DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 6 , 19 83 , to December 8 , 19 83 , that <input checked="" type="checkbox"/> (we) lost above, <input type="checkbox"/> (we) did not view the body after death.													
22b. SIGNATURE MOHAMID AL IBRAHIM MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mohamed Al Ibrahim				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEATH CERTIFICATE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. MONTH		2d. DAY		2e. YEAR		2f. HOUR	
1. DECEASED NAME		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. MONTH	
Gregory Frederick Newell								12/12/83					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 24 HRS.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.	15. A	16. M
Male	White	Dec. 18, 1964	18 YRS			12/12/83							
17. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	18. CITIZEN OF WHAT COUNTRY?	19. MARRIED	20. NEVER MARRIED	21. WIDOWED	22. DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	USA					Baltimore City							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY									
Baltimore	University Hospital Shock Trauma	Student											
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	15. CITY OR TOWN	16. INSIDE CITY LIMITS?	17. STREET ADDRESS	21136									
Maryland	Baltimore	Reisterstown	4919 Kemp Road										
18. FATHER'S NAME	19. MOTHER'S MAIDEN NAME												
Daniel Lee Newell	Mary Clare Appel												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	4919 Kemp Road										
No	215-56-6403	Mrs. Mary Clare Newell	Reisterstown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple Injuries with complications													
DUE TO, OR AS A CONSEQUENCE OF													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				3:20x 10/15/83				subj. motorcyclist lost controll & ejected					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				roadway				Greenspring Ave. & Pine Spring Lane, Md.					
22a. I certify that I took charge of the remains described above and an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
				Dep. Chief				12/12/83					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Thoams D. Smith, M.D.				111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				Dec. 15, 1983				Druid Ridge Cemetery				Pikesville Balto. Maryland	
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
A. Echhardt				Owings Mills, Md				DEC 15 1983				John J. Conick	

Production

White Dec. 17, 1966 18

Northland

Northland

Bellevue

Handel

Lee

Hawaii

Boy

Olson

Angel

212-54-0107

212-54-0107

212-54-0107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		December 21, 1983		8:15 ^A _M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 3 12		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? Unknown		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1216 Druid Hill Avenue 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-5922		17. INFORMANT ADDRESS Medical Record Maryland General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oat Cell Carcinoma of the Lung</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>November 24</u> , 19 <u>83</u> , to <u>December 21</u> , 19 <u>83</u> , that <u>he</u> (we) last saw the deceased alive on <u>December 21</u> , 19 <u>83</u> , and that <u>in</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (we) (did) (did <u>not</u>) view the body after death.							
22b. SIGNATURE <u>Keith I. Adams M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/21/83	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Keith I. Adams, M.D.		22e. ADDRESS c/o Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/26/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25. FILED BY JAN 03 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BESSIE M. NICKENS			2a. DATE OF DEATH MONTH 12 DAY 5 YEAR 83			2b. HOUR 1:10 PM	
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH 8 DAY 26 YEAR 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3302 Fairview Ave. 21216	
14. FATHER'S NAME FIRST Martin MIDDLE L. LAST Cox				15. MOTHER'S MAIDEN NAME FIRST Lula MIDDLE Rossell LAST Rossell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Philip M. Nickens 3302 Fairview Avenue			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4310 **cardio respiratory arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Massive Intracerebral Hemorrhage**

(c) **Hypertension**

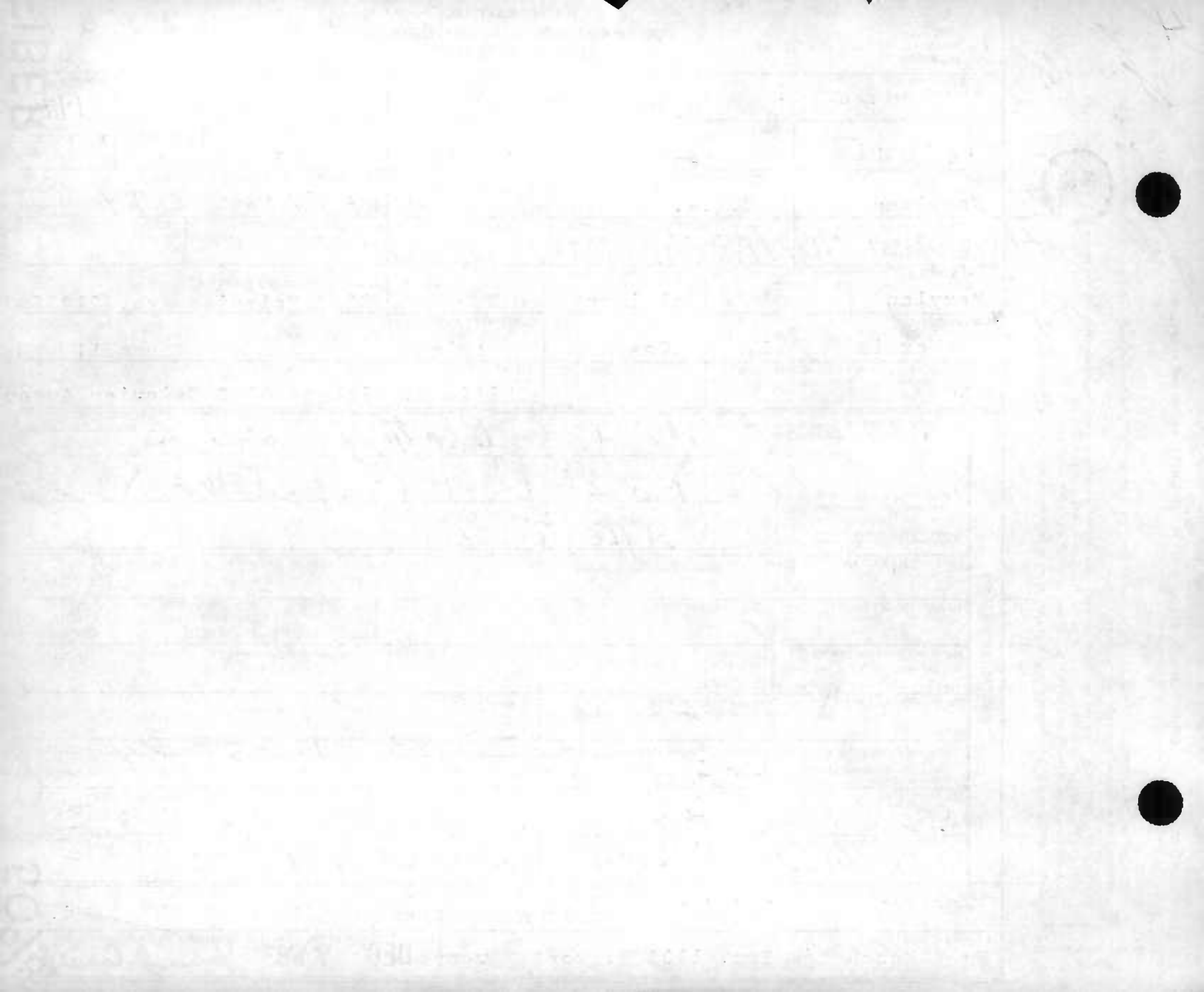
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 83 , to 12-5 , 19 83 , that (I) (we) last saw the deceased alive on 12-5 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sher Afzal Hashmi MD				DEGREE MD		22c. DATE SIGNED 12-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHER APZAL HASHMI				22e. ADDRESS 2600 LIBERTY HEIGHTS AVE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Md.	
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24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E. North Avenue		25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST RUTH	MIDDLE EVALENA	LAST NICODEMUS	DEC. 10, 1983			7:25p M		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 02 23 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		
13a. STATE MARYLAND			13b. COUNTY --	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE PRIMROSE PLACE WILKENS & CATON AVENUES, 21229	
14. FATHER'S NAME FIRST MIDDLE LAST IVAN T. ROWSEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA RAY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 341-18-0495		17. INFORMANT ADDRESS 21122 GAIL BROWN 717 205th ST.; PASADENA, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4148</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>8 DEC</u> , 19 <u>83</u> , to <u>10 DEC</u> , 19 <u>83</u> , that (I) <u>yes</u> lost saw the deceased alive on <u>10 DEC</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death.								
22b. SIGNATURE <u>Andrew Trofa</u>			DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10 DEC 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew Trofa</u>			22e. ADDRESS 900 CATON AVE. BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-14-83		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Gough</u>	

BP

952:7

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Rebecca		FIRST Norman		MONTH 12 DAY 01 YEAR 83	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 01 DAY 01 YEAR 1901	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Balto.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
14. FATHER'S NAME FIRST PHILIP MIDDLE NEWHOUSE LAST IDA		15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE UNKNOWN LAST UNKNOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-54-0793		17. INFORMANT IRVIN NEWHOUSE - 2420 HUNT DR. #21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Respiratory arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than 20 min. was found dead.	
DUE TO, OR AS A CONSEQUENCE OF (b) cause undetermined					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sepsis, URINARY infection, Congestive Heart failure, Seizure disorder					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 30 , 19 83 , to Dec. 1st , 19 83 , that (I) (we) last saw the deceased alive on Dec 1st , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M. J. Gover 9179		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/01/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRNA I. GOVER, M.D.		22e. ADDRESS 5861-D Western Run DR. Balto, MD 21209			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-4-83		23c. NAME OF CEMETERY OR CREMATORY BETH HAMEDROSH HAGODOL ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR DEC - 6 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
6010 REISTERSTOWN RD. BALTO., MD 21215					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIFFERENTIAL

20% COTTON



Handwritten notes and text on lined paper, including "A-2", "10-11", and "10-12".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUGENE B NORRIS, SR.			2a. DATE OF DEATH MONTH DAY YEAR 12 31 '83		2b. HOUR 4¹⁰ AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 02 01 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? Yes	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY W. CARROLL	13c. CITY OR TOWN SYKESVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS ZIP CODE 7610 NORRIS AVE 21184	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES NORRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA COMBASH			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 705 07 4089		17. INFORMANT ADDRESS ETHEL NORRIS Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/05 , 19 83 , to Dec 31 , 19 83 , that (I) (we) last saw the deceased alive on Dec 31 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chalontern MD		DEGREE		22c. DATE SIGNED 12/31/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALVATERRA		22e. ADDRESS UNIV OF MD HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE 1-3-83	23c. NAME OF CEMETERY OR CREMATORY St. Luke Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Howard Md	
24. FUNERAL DIRECTOR NAME Harvey W. Haight		ADDRESS Sykesville, Md		25. DATE REC'D BY REGISTRAR JAN 3 1984	
		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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James ...
No ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83332771							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
DECEASED NAME (PRINT) Florence E. Nutt				December 26, 1983				7:30A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 27 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4000 Clifton Avenue 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert Holden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Benetta Rich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 217-16-1151D		17. INFORMANT ADDRESS Helen Artes 4000 Clifton Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension Septic Shock 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure Arrhythmia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Decreased nutritional status											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) this hospital attended the deceased from December 21, 1983, to December 26, 1983, that (X) (we) lost saw the deceased alive on December 26, 1983, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) D. Human M.D.				22c. ADDRESS 827 Linden Ave. Balt. MD				22d. DATE SIGNED 12/26/83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley			

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



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Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Philip L. O'Dell						2a. DATE OF DEATH MONTH Dec. DAY 1 YEAR 83		2b. HOUR 3:45 M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH 4 DAY 20 YEAR 47		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Helper		12b. KIND OF BUSINESS OR INDUSTRY Asphalt Co.			
13a. STATE md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1927 W. Pratt St. 21223			
14. FATHER'S NAME FIRST Keith J. MIDDLE LAST O'Dell				15. MOTHER'S MAIDEN NAME FIRST Ruth MIDDLE HUBBS LAST O'Dell				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
17. SOCIAL SECURITY NO. 219-52-4330				18. INFORMANT Catherine O'Dell				19. ADDRESS 2621 Bloathfield St. 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: ENCEPHALOPATHY, METABOLIC 5715 DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL VARICES, bleeding DUE TO, OR AS A CONSEQUENCE OF (c) CRIBROSIS OF LIVER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART I. Renal Failure / Aspiration Pneumonia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/23 83 , to 12/1 83 , that (I) (we) lost saw the deceased alive on 11/30 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rgoeyoso				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/1/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Cowan + Son, Inc.				22e. ADDRESS Bon Secours Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/3/83		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION CITY OR TOWN Dorsey COUNTY MD. STATE MD.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 9 1983	
24. FUNERAL DIRECTOR NAME John J. Cowan + Son, Inc. ADDRESS 901 Hollins St.											

12/2/83
J. T. ...
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		John J. O'HARE					12	29	1983	2 AM	MM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		06 28 1931		52 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
MARYLAND		U.S.				Balt. City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		South Baltimore General Hospital		DAIRY WORKER							
13a. USUAL RESIDENCE STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD		-		Balt.				1710 But. St. 21230			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Charles O'Hare						Nance Byrne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
No.		215-28-2646		Mother O'Hare		1710 But St 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1629		CADDIC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		2 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		metastatic lung carcinoma		7 months					
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-25-1983, 19 83, to 12-29, 19 83, that (I) (we) last saw the deceased alive on 12-29, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Hand Blum		DEGREE MD		22c. DATE SIGNED 12-29-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE					
Burial		12/31/83		Holy Cross Cem.		Baltimore Md. 21230					
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home Inc. 1501 E. Fort Ave 21230		ADDRESS BALTO. MD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Conner					
				DEC 30 1983							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STANDARD INDUSTRIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate must be signed by the attending physician and completely filled in by the funeral director. The law requires that the death certificate be executed within 24 hours after death. The certificate must be signed by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 3B, the medical examiner must be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA C. Catherine O'Hayer				2a. DATE OF DEATH MONTH DAY YEAR 12 - 17 - 1983			2b. HOUR 6:15 PM	
3. SEX FEMALE		4. RACE WHITE AMERICAN		5. DATE OF BIRTH MONTH DAY YEAR 06 - 06 - 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? AMERICA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Domestic		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3613 FAIRHAVEN AVE 21226.			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE WISE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-54-4234		17. INFORMANT ADDRESS Paul P. Klender 21093 2108 Fountain Hill Dr.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 BRAIN STEM STROKE, CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM STROKE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, ATRIAL FIBRILLATION.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-13-1983 to 12-17-1983, that (I) (we) lost now the deceased alive on 12-17-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mahesh Moudra				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-17-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOONDRA MAHESH				22e. ADDRESS 1028 RUSTLING OAKS DR. MILLERS HILL MD 21108							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/1983		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.					
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				24b. ADDRESS Baltimore, Md., 21225 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Grieb			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR LISETTE EDITH OLSEN							
1. DECEASED NAME (TYPE OR PRINT) LISETTE E. OLSEN				2a. DATE OF DEATH MONTH DAY YEAR DEC. 14 1983		2b. HOUR 2:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1250 Grey Stone Road		13f. CITY OR TOWN 21227					
14. FATHER'S NAME FIRST MIDDLE LAST John M. Watts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Raley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-05-0658		17. INFORMANT Katherine H. Jensen		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ORGANIZING PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SEVERE GENERALIZED CALCIFYING ATHEROSCLEROSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E. Taylor				DEGREE M.D.		22c. DATE SIGNED 12/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR				22e. ADDRESS ST AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/16/83		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR DEC 20 1983			
1630 Edmondson Avenue, Catonsville, Md. 21228				25b. REGISTRAR'S SIGNATURE James E. Taylor			

BP

2000

1000 Commonwealth Avenue, Bostonville, Md. 21220

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JOHN FREDERICK O'NEALE			12 17 83			6:20 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	WHITE	02 08 07	76 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	503 S. PULASKI STREET, 21223		OIL BURNER			OIL CO.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS / ZIP CODE			13c. CITY OR TOWN		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND ---			503 S. PULASKI STREET, 21223			BALTIMORE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST			FIRST MIDDLE LAST					
GEORGE WASHINGTON O'NEALE			UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			218-10-7071			GEORGE S. O'NEALE 503 S. PULASKI ST. 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Brain Anoxia</u>								<u>Immediate</u>
3310 DUE TO, OR AS A CONSEQUENCE OF <u>CNS Coma</u>								<u>2 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF <u>Alzheimer's Disease + Bone metastases</u>								<u>2 yrs</u> <u>2 wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>83</u> , to <u>12/17</u> , 19 <u>83</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/15</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Wm C Waterfield</u>			<u>MD</u>			<u>12/19/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
WILLIAM C. WATERFIELD, M.D.			ST. AGNES HOSPITAL, ONCOLOGY DEPARTMENT					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			12-21-83		MEADOWRIDGE MEM. PK. 21229		ELKBRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.		DEC 21 1983		<u>John J. Conner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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NO.	ED.	ST.	DATE	TIME	STATE
1	10	30	10	10	STATE
2	10	30	10	10	STATE
3	10	30	10	10	STATE
4	10	30	10	10	STATE
5	10	30	10	10	STATE
6	10	30	10	10	STATE
7	10	30	10	10	STATE
8	10	30	10	10	STATE
9	10	30	10	10	STATE
10	10	30	10	10	STATE

STATE OF NEW YORK

IN SENATE

JANUARY 10, 1910

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON JANUARY 10, 1909

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS

1910

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HERMINA S ORRSON			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10, 1983		2b. HOUR 01:16am
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1948		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIM ORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Jarrettsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Leo Pietrowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Bernadina Wydra		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 165-40-7416	17. INFORMANT ADDRESS John M. Orrson same as above	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2832

DUE TO, OR AS A CONSEQUENCE OF

(b) **hypertension**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) **paroxysmal nocturnal hemoglobinuria**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/10 19 83 , to 12/10 19 83 , that (he) (she) (it) (we) (you) (they) (did) (did not) view the body after death.			
22b. SIGNATURE M. G. Gladden	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Threlkeld	22e. ADDRESS Johns Hopkins Hospital		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/13/83	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Pylesville, Harford, Md.
24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1983	25b. REGISTRAR'S SIGNATURE John J. Canine

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 YOUR OWN. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										32178 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE W. ORWIG										2a. DATE OF DEATH KNOWN ESTI. MONTH DAY YEAR 12 1 1983	
2. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. MAL 2 WHITE DEC. 28, 1959 23 YRS.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 1 1983	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY MARYLAND BALTIMORE University Hosp. (STU) DRIVER Pyroclator										7b. HOUR 7:38 a.m.	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS MARYLAND BALTIMORE 21236 7936 BELRIDGE ROAD											
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HOWARD W. ORWIG, SR. CATHERINE SUSAN BUTLER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS NO 213784640 FAMILY RECORDS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic trauma 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:25 AM 12-1-1983										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/tractor trailer collision.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road										21f. LOCATION STREET CITY OR TOWN COUNTY STATE JFK Highway Cecil Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-1-83											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE DEC. 5, 1983 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD Cem.										23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES HARFORD 8800 RD.										25a. DATE REC'D. BY REGISTRAR DEC 8 1983 25b. REGISTRAR'S SIGNATURE John J. Carver	

NOTION 9381A

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WIND



APR 21 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
EDWIN		H.		OWEN,		JR.		12-22-83					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	11-27-50		33 YRS.						12-22-83		2:54A	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		South Baltimore General Hospital		Sept. employed		Plumber							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		A.A.Co.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		401 Cedar Hill Rd. Balto. Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Edwin		Betty											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		214-56-0274		Mrs. Betty Owen, Same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8150 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:37AM 12-22-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		driver of auto/fixed object collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hammonds Lane & Cedar Hill Lane Anne Arundel Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		12-22-83							
Margarita A. Korell, M.D.		Assistant		SIGNED									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Margarita A. Korell, M.D.		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Dec. 24, 1983		Glen Haven Mem. Park		Glen Burnie, A.A.Co. Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Mcully Funeral Home, 237 E. Patapsco Ave. Balto.		Md. 21225		DEC 22 1983		John J. Corbett							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. THE FUNERAL
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE OWENS			2a. DATE OF DEATH MONTH DAY YEAR 12 09 83		2b. HC 135 P.M.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 04 07 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Co. VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4015 PENHURST AVE 21215	
14. FATHER'S NAME FIRST MIDDLE LAST George James Owens			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218 02 8307		17. INFORMANT ADDRESS Rev. Milton Minniefield 3921 Belview AVE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ADULT RESPIRATORY DEPRESS SYNDROME**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4 Days**

5185
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MYOCARDIAL INFARCTION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 83 , to 12/9 , 19 83 , that (I) (we) last saw the deceased alive on 12/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Seth Jay Weber		DEGREE MD		22c. DATE SIGNED 12/09/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SETH WEBER, MD		22e. ADDRESS SINAI HOSPITAL, BALTIMORE MD			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE 12-14-83	23c. NAME OF CEMETERY OR CREMATORY Mid. National Mem. Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Looseville Maryland
24. FUNERAL DIRECTOR NAME William J. Spies		ADDRESS 1639 N. Broadway	25a. DATE REC'D. BY REGISTRAR DEC 12 1983
		25b. REGISTRAR'S SIGNATURE James J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HIBEL



NO 10 01 23

Ret.

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Entries on page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Hortense OWENS				2a. DATE OF DEATH MONTH DAY YEAR December 23, 1983		2b. HOUR 12:15^A	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 6 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 1601 Retreat Street Baltimore, Maryland 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Carey Jasper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Morgan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 214-12-4791		17. INFORMANT ADDRESS Maude Wilkerson 604 Gold Street Baltimore, Maryland 21217			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Probable Aspiration Pneumonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell Carcinoma of the Lung with XXXXXXXXXXXXXXXXXXXX mediastinal involvement.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension Hypertension; Diabetes Mellitus; Hypercalcemia.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that the (this hospital) attended the deceased from December 21 , 19 83 , to December 23 , 19 83 , that we (we) last saw the deceased alive on December 23 , 19 83 , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.							
22b. SIGNATURE Harry E. Nervino, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry E. Nervino M.D.				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/1983		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME NUTTER & SONS				ADDRESS 2501 Gwynns Falls Pkwy. BALTO. Md. 21216		DATE REC'D. BY REGISTRAR DEC 27 1983	
FUNERAL HOME INC.						REGISTRAR'S SIGNATURE John J. Canish	

12-13

December 13, 1983

OWING

POSTING

Bellevue City

U. S. A.

Marland General Hospital

to be covered

1981

11-11-79

Probable aspiration pneumonia

Recurrent cell carcinoma of the lung with

metastatic involvement.

Diagnosis: Diabetes Mellitus; Hypercholesterolemia.

82 83

December 23

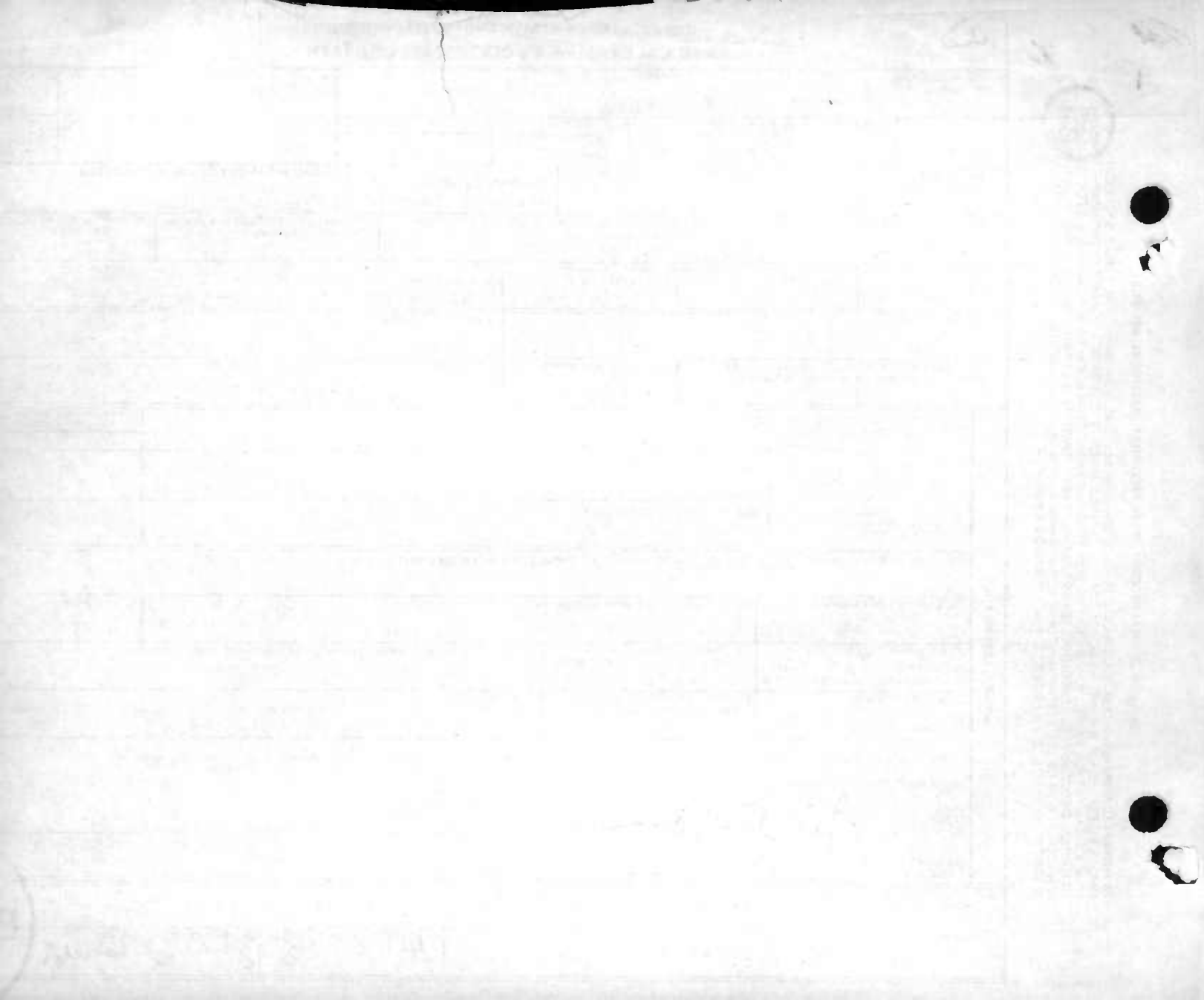
December 21

November 23

12/23/83

Harry E. Weir, M.D.

c/o Marland General Hospital

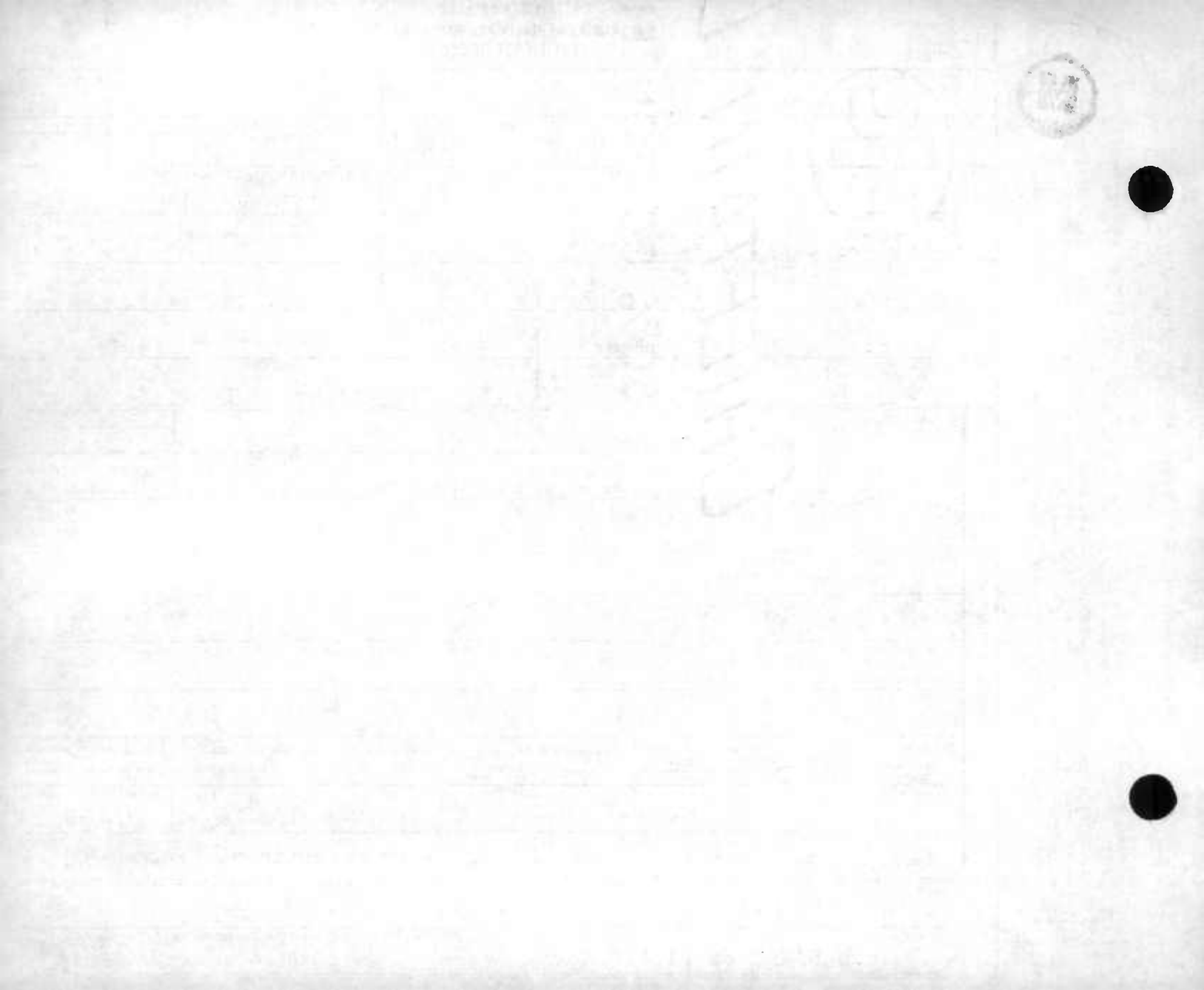


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROSMAN L. PALMER						2a. DATE OF DEATH MONTH DAY YEAR 12 31 83		2b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 6 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21213 2001 E. Lafayette Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST George E. Palmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214-14-2873		17. INFORMANT ADDRESS M. Bernice Palmer 2001 E. Lafayette Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4254 DUE TO, OR AS A CONSEQUENCE OF (b) RECURRENT VENTRICULAR TACHYCARDIA DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEAR HISTORY OF RECURRENT VT	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CARDIOMYOPATHY											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (his hospital) attended the deceased from JULY 19 81 , to DECEMBER 19 83 , that (1) (we) lost saw the deceased alive on DECEMBER 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Patricia A. Savadel, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. SAVADEL				22e. ADDRESS JOHNS HOPKINS HOSPITAL BALTO, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/5/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Cooney			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		DECEMBER 5, 1983		11:15 _M
RUSSELL		L.		PANNEBAKER				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	Oct. 12, 1945		38		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Md.		U. S. A.				BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE		THE JOHNS HOPKINS HOSPITAL				Machinest		D. Schwartz
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
		Md.		---	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS				
Clifford H.		Maxine		124 N. Lakewood Ave. 21224				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				
Yes		?-Reserve		Mrs. Marie G. Pannebaker-Balto. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>83</u> , to <u>12/5</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Rowenn Roubenoff</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/5/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rowenn Roubenoff</u>		22e. ADDRESS <u>600 N. WOLFE ST.</u>		22f. ADDRESS <u>JOHNS HOPKINS HOSP, BALTIMORE</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/9/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Gargens - Belair, Maryland</u>		
24. FUNERAL DIRECTOR NAME <u>John A. Moran, Inc. Funeral Home</u> ADDRESS <u>3000 E. Baltimore, St., Balto., Md. 21224</u>		25a. DATE REC'D. BY REGISTRAR <u>7 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
 THE JOINTS WORKING HOSPITAL
 BIRMINGHAM
 1915

20% COTTON
 CHEFEMIN
 100 N. WILKIN ST.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

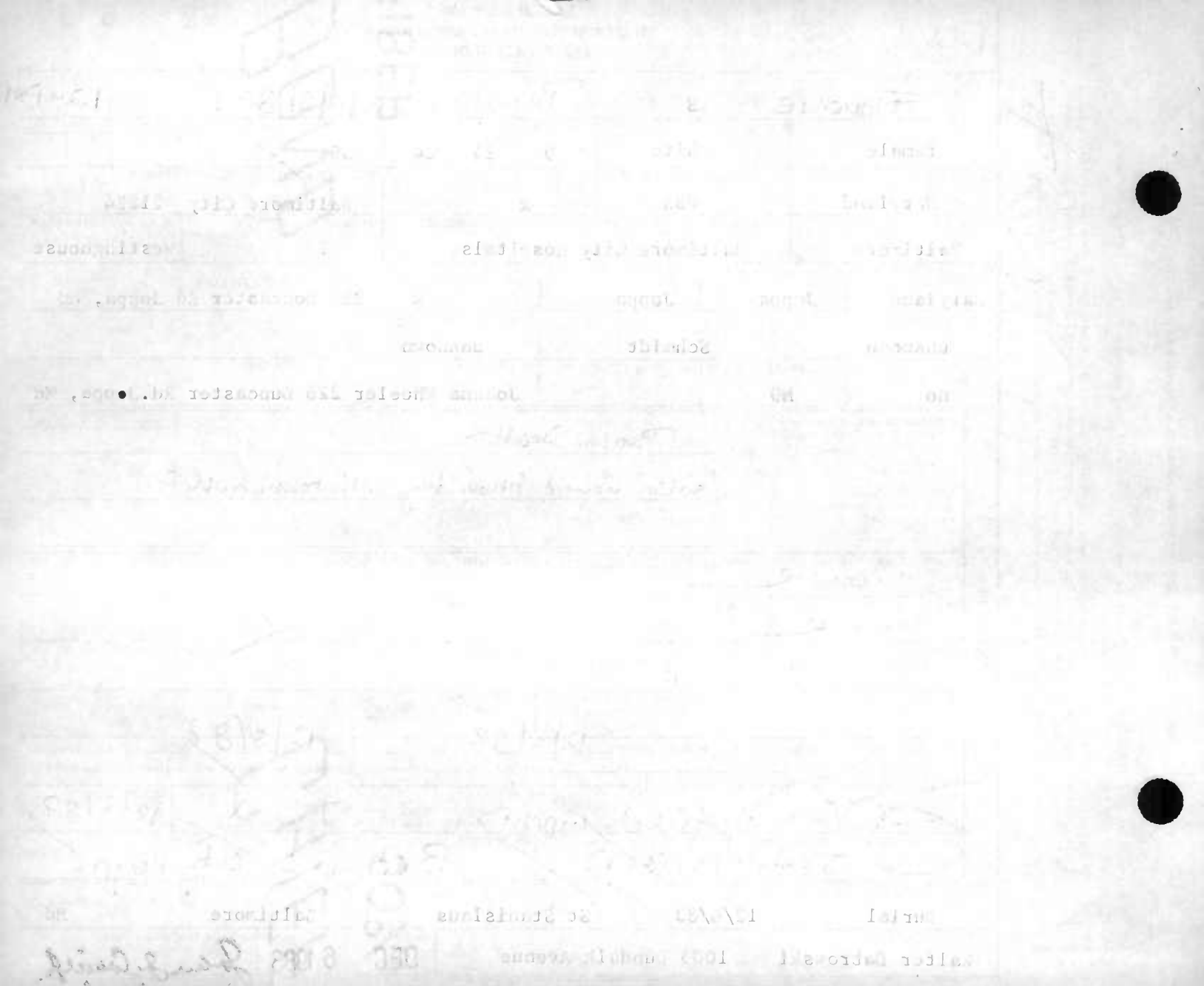
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence S Papalas		2a. DATE OF DEATH MONTH DAY YEAR 12/5/83		2b. HOUR MIN. 1.24 PM	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9 24 24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City 21224 MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ?		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Joppa	13c. STREET ADDRESS / ZIP CODE 226 Doncaster Rd Joppa, Md 21085		
14. FATHER'S NAME FIRST MIDDLE LAST unknown Schmidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ADDRESS Joanna Wheeler 226 Duncaster Rd. Joppa, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4300 Brain Death IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) subarachnoid hemorrhage with herniation DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none					
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore City Hosp.	
22a. I certify that (I) (this hospital) attended the deceased from 12/5/83 , 19____, to 12/5/83 , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John J. Conner		DEGREE MD		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. CONNER		22e. ADDRESS Baltimore City Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/83		23c. NAME OF CEMETERY OR CREMATORY St Stanislaus	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md					
24. FUNERAL DIRECTOR NAME Walter Dabrowski		ADDRESS 1005 Dundalk Avenue		25a. DATE REC'D. BY REGISTRAR DEC 6 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified as soon as possible.



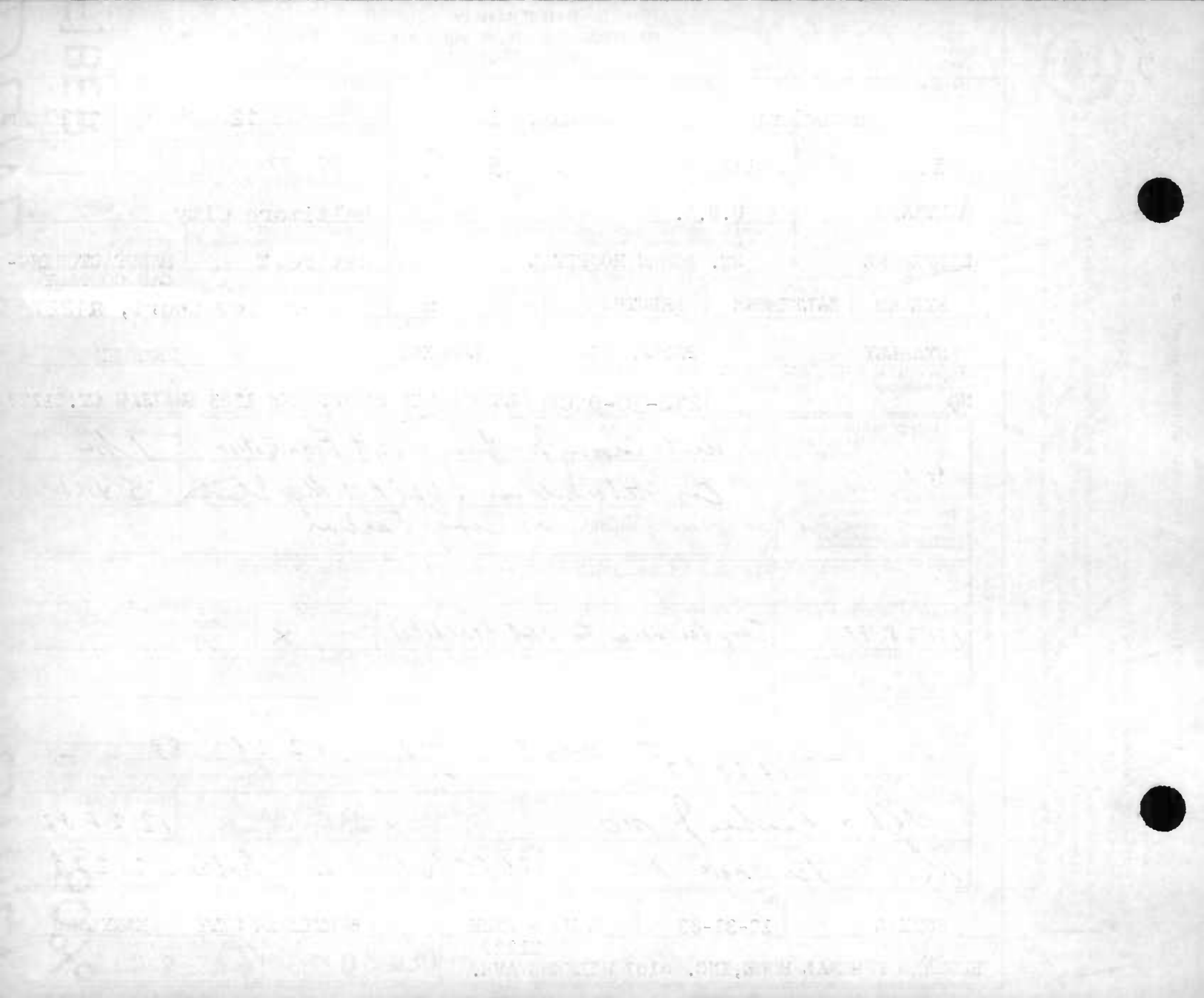
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.35
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WENCELAUS PAPLONSKIS			2a. DATE OF DEATH MONTH DAY YEAR 12 28 83		2b. HOUR 1120 AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06 15 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING-CAN COMPANY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN ARBUTUS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY PAPLONSKIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUDWIKA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-30-0108		17. INFORMANT ADDRESS ALEKSANDRIA PAPLONSKIS 1203 SWALLOW CT. 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency - Vent. Fibrillation 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Cor. Arteriosclerosis - Old Ant. Myo. Infarct DUE TO, OR AS A CONSEQUENCE OF (c) ad Cong. Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs 5 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO						
19a. DATE OF OPERATION 12-28-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Large Prolapsed Fm Vent. Standstill		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from May 31 , 19 78 , to 12-28 , 19 83 , that (I) (we) last saw the deceased alive on 12-28-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kyle G. Swisher MD		DEGREE MD		22c. DATE SIGNED 12-28-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kyle G. Swisher MD		22e. ADDRESS 3455 Wilkens Ave - Baltm 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-31-83		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND						
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 30 1983		
		25b. REGISTRAR'S SIGNATURE John J. Canine				

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John J. Connelley

UNITED STATES GOVERNMENT

DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST THOMAS		MIDDLE A.		LAST PARROTT		2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> 12 14 1983		2b. HOUR M	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 2 17 1920	6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 15 1983		2d. HOUR 11:26 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1509 N. Patterson Park Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1509 N. Patterson Park 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Parrott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Cockrell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-12-0237		17. INFORMANT ADDRESS Ann King 1320 N. Broadway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12-15-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (S) Burial		23b. DATE 12/19/83		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave						25a. DATE RECEIVED BY REGISTRAR DEC 19 1983		25b. REGISTRAR'S SIGNATURE 			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWIN L PATTERSON			2a. DATE OF DEATH MONTH DAY YEAR 12-08-83			2b. HOUR 16³⁶ M			
3. SEX Male		4. RACE White or Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06-26-07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Statesville, M.C. - U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor - Penn. RR		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 303 Locust Drive-21228	
14. FATHER'S NAME FIRST MIDDLE LAST Lemuel Bruce Patterson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Webb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237-01-6112		17. INFORMANT 303 Locust Drive-Batonsville, Md. 21228 Mrs. Louise T. Patterson					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4960

IMMEDIATE CAUSE (a) **Brain Anoxia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **broncho pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic Obstructive Pulmonary Disease**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Cor Pulmonale

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 11/25 , 19 83 , to 12/8 , 19 83 , that (I) (we) lost saw the deceased alive on 12/8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Gordon				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. GORDON				22e. ADDRESS 900 Caton Ave Balt. Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/1983		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery Statesville, N.C.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A. ADDRESS 736 Edmondson Ave. - Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE Joan J. Canfield	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR 76 HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Ethel Patterson				12-25-83 M			
3. SEX F		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 4 13 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crescent Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto. Co.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Albert		15. MOTHER'S MAIDEN NAME Ethel Milliot		13e. STREET ADDRESS 4110 Keithland Ave. 21207			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Allie O Mc Nair			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease				6 years			
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19 72 to November 19 83, that (I) (we) last saw the deceased alive on November 23, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel R. Owings, Jr., M.D. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel R. Owings, Jr., M.D.				22e. ADDRESS 409 N. Carey St. Balto, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-1983		23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Vernon R. Bailey ADDRESS 1348 N. Calhoun Street				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Geraldine Paul			2a. DATE OF DEATH MONTH DAY YEAR 12/19/83			2b. HOUR 9:13 AM			
3. SEX F		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 08/12/99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nursing Home 21215				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plant		12b. KIND OF BUSINESS OR INDUSTRY Noxema	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY Balt.		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3978 Edgehill Apt E 21211	
14. FATHER'S NAME FIRST MIDDLE LAST James H. Riley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Alice Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 215-03-4222		17. INFORMANT ADDRESS William J. Merson 34			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiovascular collapse**

4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASCVD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

COPD, hypothyroidism, seizure disorder

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 83 , to 12/19 , 19 83 , that (I) (we) last saw the deceased alive on 12/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Ford MD				DEGREE MD		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. FORD				22e. ADDRESS Belvedere & Greenspring Ave.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Lorraine		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Conish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John n PAULUS			2a. DATE OF DEATH MONTH DAY YEAR 12-19-83			2b. HOUR 3⁴⁵ M		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 25 99		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ORATOR MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supt. Rowan Controller Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Rodgers Forge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John J. Paulus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dumler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				
16b. SOCIAL SECURITY NO. 215-07-1847 A		17. INFORMANT ADDRESS Mrs. Margaret E. Paulus-323 Regester Ave-12						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary failure 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple pressure ulcers (c) S/P CVA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Dec 15 , 19 83 , to Dec 19 , 19 83 , that (I) (we) last saw the deceased alive on Dec 19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Julian W. Reed				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN W. REED				22e. ADDRESS 611 S. CHASE ST. BALTO. MD. 21236				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto City		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home-6500 York Rd. 21212				25a. DATE REC'D. BY REGISTRAR DEC 21 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

20% COTTON
MADE IN U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR **aka Denver C. Payne**

1. DECEASED NAME (TYPE OR PRINT) Denver Payne			2a. DATE OF DEATH MONTH DAY YEAR 12-28-83			2b. HOUR 7:45A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 8 11		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Davidson Chen	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21225 204 Townsend Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL PAYNE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Marple					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 232-07-7897		17. INFORMANT Ruby M. Payne			
(IF YES, GIVE WAR OR DATES) WW II				ADDRESS Same as 13e.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UPPER GASTROINTESTINAL BLEEDING 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) STRESS INDUCED ULCER DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC LUNG CARCINOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DEC 27
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **—**

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —			
22a. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 83 , to 12-28 , 19 83 , that (I) (we) lost saw the deceased alive on 12/28/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Florante Richard Manzan				DEGREE MD		22c. DATE SIGNED 12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MANZAN				22e. ADDRESS 3001 St. Hanover St. Balt. Md. 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk - Glen Burnie - A.A. - Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
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24. FUNERAL DIRECTOR George J. Gonca		ADDRESS 4001 Ritchie Hwy Balto		DATE RECORDED BY REGISTRAR JAN 4 1984		SIGNATURE John J. Gonca	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

George A. Jones 4001 Wichita Hwy Suite 100
12/30/65 for review for A.A. Jones



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

83 32794

 FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MORRIS PAZORNIK		2a. DATE OF DEATH MONTH DAY YEAR 12 23 83		2b. HOUR 11:55 AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCER		12b. KIND OF BUSINESS OR INDUSTRY FOODS
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MOTTEL PAZORNIK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHAVA FELDMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO		16b. SOCIAL SECURITY NO. 219-32-0621		17. INFORMANT MRS. SOPHIE PAZORNIK 3702 LABYRINTH RD. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 55 , to 12-23-83 , that (I) (we) last saw the deceased alive on 12-22-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. DECKELBAUM, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-23-83	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) J. DECKELBAUM, M.D.		23b. ADDRESS 3635 OLD COURT RD. BALTO 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 25, 1983		23c. NAME OF CEMETERY OR CREMATORY SWINICHER WOLINER BENEV. ASSOC. BALTIMORE MD	
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bascom Wood Pendleton			2a. DATE OF DEATH MONTH DAY YEAR 12-20-83		2b. HOUR 5:45 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03-02-04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. - - - -
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Coast Guard		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD COUNTY A.A.			13b. CITY OR TOWN Glen Burnie	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bascom White Pendleton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Watson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 219-26-9200		17. INFORMANT ADDRESS Severn, Md 21144 Alan Pendleton 7871 Chestnut Leaf Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2390 IMMEDIATE CAUSE (a) Hypovolemic irreversible shock DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding intraperitoneal tumor DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 12/19/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory laparotomy, abd. tumor		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from December 19, 1983 , to December 20, 1983 , that (I) (we) last saw the deceased alive on December 20, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald H. Gonzalez DEGREE				22c. DATE SIGNED 12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald H. Gonzalez				22e. ADDRESS South Baltimore General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/21/83	23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md
24. FUNERAL DIRECTOR NAME George J. Gonca 4001 Ritchie Hwy Balto Md				25a. DATE REC'D. BY REGISTRAR DEC 23 1983	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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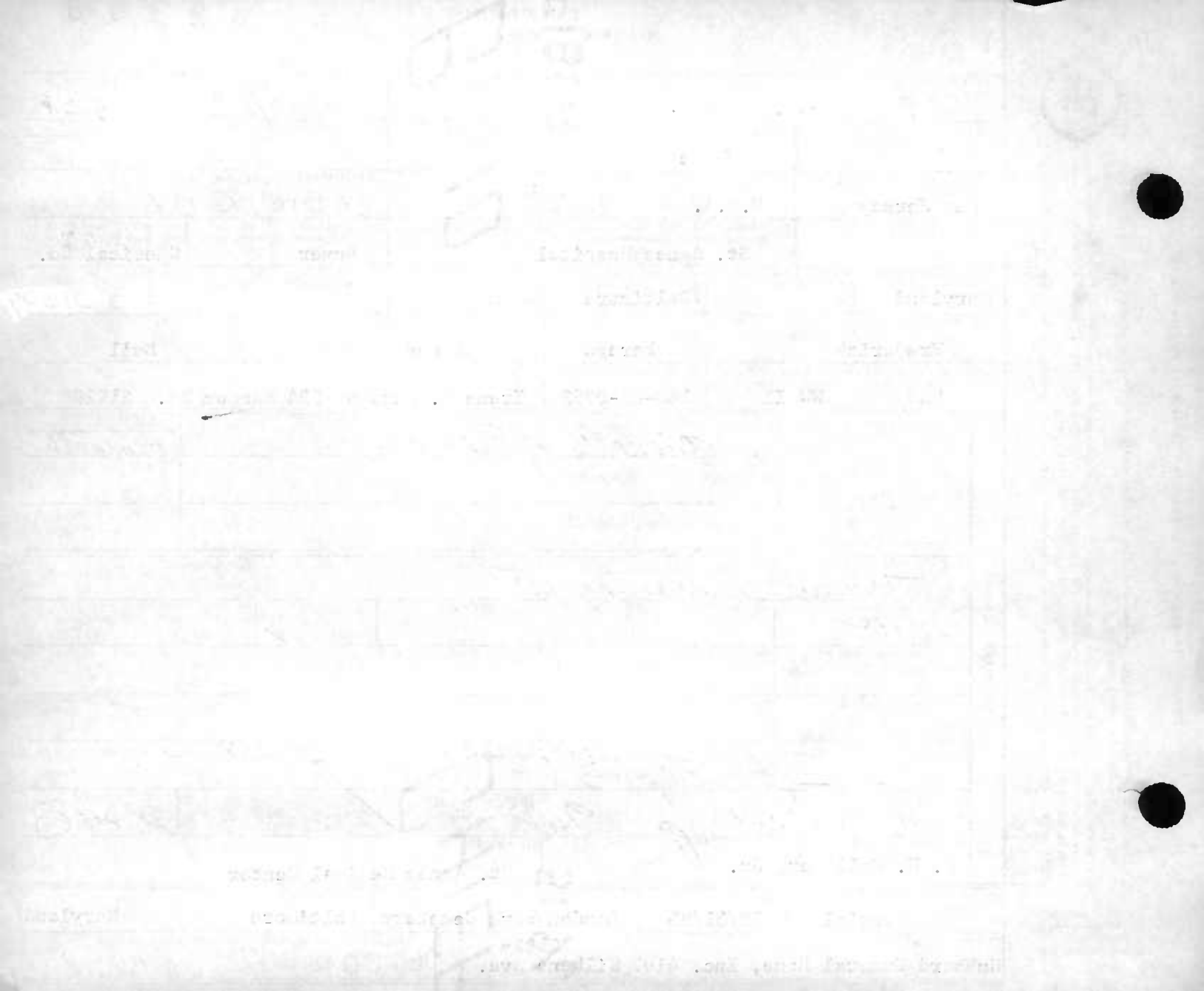
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FREDERICK D. PEREGO		12/28/83	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	MONTH 3 DAY 15 YEAR 12	71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	U.S.A.		Balto. City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY M & T
Baltimore	St. Agnes Hospital	Buyer	Chemical Co.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS / ZIP CODE	
FREDERICK D. PEREGO	AGNES BULL	534 Random Road 21229	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
YES	WW II	Irene G. Perego 534 Random Rd. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of stomach</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>terminal cardiac arrest</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
none		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1970</u> , 19____, to <u>Dec 28</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>W. K. Gallagher, Jr.</u>		22c. DATE SIGNED <u>28 Dec 83</u>	22d. ADDRESS St. Agnes Medical Center
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/31/83	Loudon Park Cemetery	Baltimore Maryland
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.	DEC 30 1983	<u>Sam E. Carver</u>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

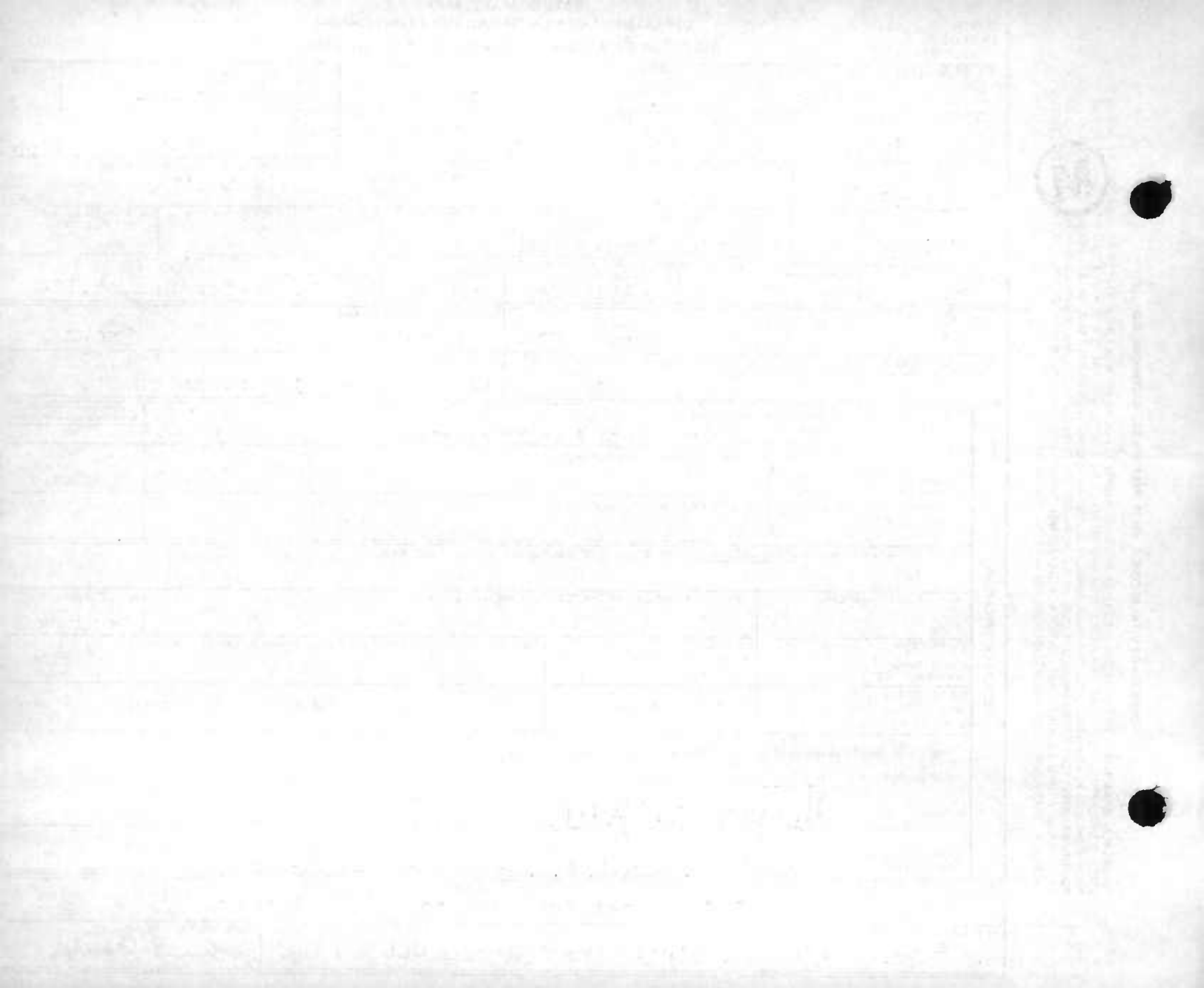
DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST JULE			MIDDLE B.			LAST PERRY III			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-16-83			21. DATE OF DEATH MONTH DAY YEAR 12-16-83			22. HOUR M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 9 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 6		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS. HOURS MIN		9. DATE PRONOUNCED DEAD 12-16-83			10. HOUR 12:14					
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City								
15. CITY OR TOWN OF DEATH Baltimore				16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				18. KIND OF BUSINESS OR INDUSTRY								
19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Baltimore				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 21202 127 S. Exeter St. Apt. 12C								
14. FATHER'S NAME FIRST MIDDLE LAST Jule B. Perry II				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcie Brown				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				17. SOCIAL SECURITY NO. N/A				18. INFORMANT ADDRESS Apt. 12C Marcie Brown 127 S. Exeter St.				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE Margarita A. Koroll				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12-17-83								
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/22/83				23c. NAME OF CEMETERY OR CREMATORY Eastview Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.								
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.				ADDRESS 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 21 1983				25b. REGISTRAR'S SIGNATURE John J. Grief								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>RUDOLPH</u> MIDDLE (<u>PERRY</u>) LAST <u>PERRY</u> (<u>RUDOLPH</u>)		2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> <u>14</u> <u>83</u>		2b. HOUR <u>230</u> P
3. SEX <u>Male</u>	4. RACE <u>Black</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>12</u> <u>24</u> <u>30</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N. Carolina</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BALTIMORE CITY HOSPITALS</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Maryland</u>		13b. COUNTY	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <u>Charlie</u> MIDDLE LAST <u>Perry</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Ada</u> MIDDLE LAST <u>White</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>238-38-9438</u>		17. INFORMANT <u>Catherine Perry</u>
		ADDRESS <u>2107 Chantilla Rd. 21228</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2030</u> <u>PERMANENT ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE MYELOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (this hospital) attended the deceased from <u>7-DEC</u> 19 <u>83</u> to <u>14-DEC</u> 19 <u>83</u> , that (we) last saw the deceased alive on <u>14 DEC</u> 19 <u>83</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Karen E. M. Szauter MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>14-DEC</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAREN E. M. SZAUTER</u>		22e. ADDRESS <u>Balt. City Hosp. 4990 Eastern Ave Baltimore, MD 21224</u>		
23a. BURIAL, CREMATION, REMOVAL (SP) <u>BURIAL</u>	23b. DATE <u>12/19/83</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR (NAME) <u>F/H</u> <u>Wm C March Inc, 1101 E North Avenue</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 15 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard Peters, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1983			2b. HOUR 130 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 23, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5323 Todd Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift Operator		12b. KIND OF BUSINESS OR INDUSTRY Food Fair	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 5323 Todd Ave.		21206	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Peters		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Adams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-28-3936		17. INFORMANT ADDRESS Ennis Peters 5323 Todd Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Oat cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 19 83, to Dec 15 19 83, that (I) (we) lost saw the deceased alive on ~ Dec 15 19 83, and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Lai, M.D.				22c. DATE SIGNED 12/25/83		22d. ADDRESS Mercy Hospital Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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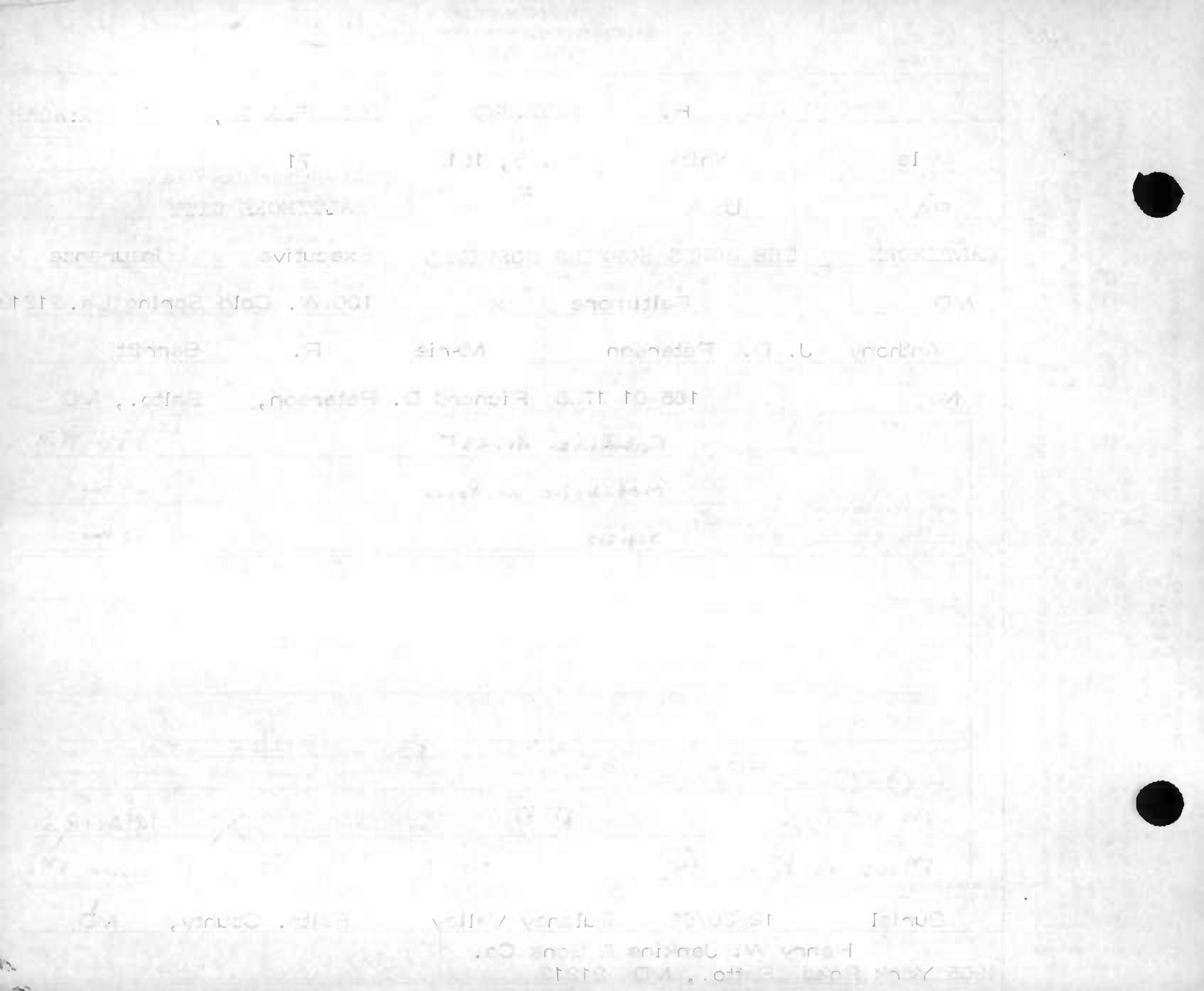
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 32800			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES H. PETERSON				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1983		2b. HOUR 09:40AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony J. D. Peterson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie R. Barritt		13e. STREET ADDRESS / ZIP CODE 100 W. Cold Spring La. 21210			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165 01 0755		17. INFORMANT ADDRESS Richard D. Peterson, Balto., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 0389 DUE TO, OR AS A CONSEQUENCE OF: (b) metabolic acidosis DUE TO, OR AS A CONSEQUENCE OF: (c) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9:50 AM 24 hrs. 48 hrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 83 , to 12/26 , 19 83 , that (I) (we) lost saw the deceased alive on 12/26 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) not view the body after death.							
22b. SIGNATURE M. Ratcliffe DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark B. Ratcliffe				22e. ADDRESS 600 N. Wolfe St. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/83		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

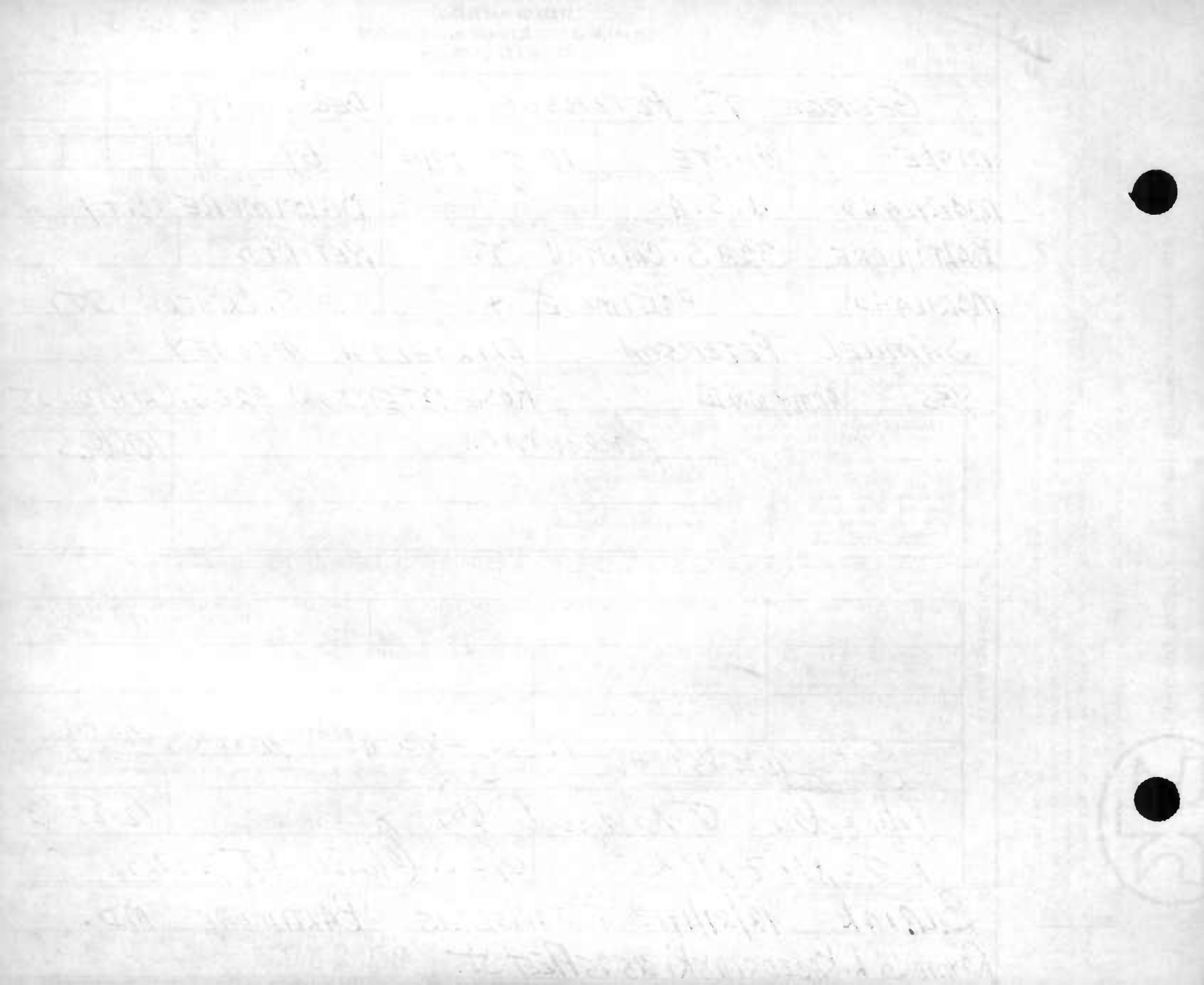
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE T. PETERSON			2a. DATE OF DEATH MONTH DAY YEAR DEC. 22, 1983			2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 23 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 323 S. CLINTON ST.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 323 S. CLINTON ST.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL PETERSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH MOONEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. ARMY WWII		17. INFORMANT ADDRESS ROSE PETERSON 323 S. CLINTON ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 12-22-83 11:00 AM to 12-22-83 7:00 PM , and that (1) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Theodore T. Nyznik DEGREE								22c. DATE SIGNED 12-23-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. T. NIZNIK				22e. ADDRESS 419 S. Charles St 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/27/1983		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE M.D.		
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI				24b. ADDRESS 2525 FLEET ST.		25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen S. Peterson				2a. DATE OF DEATH MONTH DAY YEAR 12 18 83			
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 23 09		2b. HOUR 4:20 PM	
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. IF UNDER 1 YEAR MONTHS DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC.		7c. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Jenkins Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1000 S. Caton Ave. 21229		12b. KIND OF BUSINESS OR INDUSTRY Nursing			
13a. STATE Maryland				13b. CITY OR TOWN Hyattsville P.G.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Peterson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Schwab			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578-01-0711		17. INFORMANT Mary E. Frye	
				ADDRESS Hyattsville, Md.		6923 Decatur Place 20784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) CH - colon - sigmoid colon cancer DUE TO, OR AS A CONSEQUENCE OF (b) metastatic adenocarcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-24-82, 19, to 12-18-83, 19, that (I) (we) last saw the deceased alive on 12-17-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George Angov				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-19-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ANGOV				22e. ADDRESS 3350 Wilkens Dr. Balt.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 21229 41007 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 21 1983	
				25b. REGISTRAR'S SIGNATURE John J. Connelley			

BP

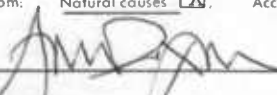



NOTION 1111



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LORETTA (BROWNIE) B. PETTIGREW										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 22 19 83	
2. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY 1921 4 29		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR 5:10 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1810 N. Washington St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1810 NORTH WASHINGTON ST. 21218		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN BUNDY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LILLIEN BROWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 214-22-5425		17. INFORMANT ROOSEVELT PETTIGREW 1810 N. WASHINGTON ST. 21218				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-23-83			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY			23d. LOCATION BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR MARSHALL W. JONES, JR. 4101 EDMONDSON AVENUE/BALTO., Md 21229						25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

Item 19b film 587 1-19-84
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE Teresa PFAFF			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 29, 1983			2b. HOUR 8:25pm			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr 9, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL CORP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Balto, Md. 21206 5746 Cedonia Ave, Apt. D.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Rolle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Appolonia Hartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. 212-74-9056		17. INFORMANT ADDRESS Margaret Trenner, 7919 Gray Haven Rd. Balto, Md. 21222			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction 7 days</u> 7454 (b) DUE TO, OR AS A CONSEQUENCE OF VENTRICULAR SEPTAL DEFECT (c) DUE TO, OR AS A CONSEQUENCE OF SEPSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 11-25-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TEMPORARY PACEMAKER, A.V. BLOCK				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from NOV. 23, 1983, to NOV. 29, 1983, that I (we) last saw the deceased alive on NOV. 29, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE John R. Bartholomew				DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. BARTHOLOMEW MD				22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY BALTO. MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/2/83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, 3331 Brehms La,				25. DATE REC'D. BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

UNIVERSITY OF MICHIGAN

UNIVERSITY OF MICHIGAN

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MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be marked above.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Mary Pfisterer				2a. DATE OF DEATH MONTH DAY YEAR December 7, 1983		2b. HOUR A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 25 12		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Reads Drug St.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jasper Wells				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Schilsinger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-16-6406		17. INFORMANT ADDRESS Joseph E. Pfisterer, Jr. 5512 Highridge St. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, massive, myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to 12/1 , 19 83 , that (I) (we) last saw the deceased alive on 12/1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Fernando Queral				DEGREE M.D.		22c. DATE SIGNED 12/7/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fernando Queral				22e. ADDRESS 301 McMecken St. Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

LABORATORY REPORT

DATE	TIME	TEST	RESULT	REMARKS
12/15/63	10:00	Urea Nitrogen	12.0	
12/15/63	10:00	BUN	12.0	
12/15/63	10:00	Creatinine	2.0	
12/15/63	10:00	Glucose	100	
12/15/63	10:00	Electrolytes		
12/15/63	10:00	Calcium	9.0	
12/15/63	10:00	Phosphorus	3.0	
12/15/63	10:00	Serum Bilirubin	1.0	
12/15/63	10:00	Alkaline Phosphatase	100	
12/15/63	10:00	Aspartate Aminotransferase	10	
12/15/63	10:00	Alanine Aminotransferase	10	
12/15/63	10:00	Lactate Dehydrogenase	1000	
12/15/63	10:00	Prothrombin Time	12.0	
12/15/63	10:00	Partial Thromboplastin Time	30.0	
12/15/63	10:00	Fibrinogen	300	
12/15/63	10:00	D-Dimer	0.5	
12/15/63	10:00	Hemoglobin	12.0	
12/15/63	10:00	Hematocrit	35.0	
12/15/63	10:00	Red Blood Cell Count	4.0	
12/15/63	10:00	White Blood Cell Count	10.0	
12/15/63	10:00	Differential White Blood Cell Count		
12/15/63	10:00	Platelet Count	150,000	
12/15/63	10:00	Urinalysis		
12/15/63	10:00	Stool Analysis		
12/15/63	10:00	Sputum Analysis		
12/15/63	10:00	CSF Analysis		
12/15/63	10:00	Other Tests		

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Urea Nitrogen

RESULT: 12.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: BUN

RESULT: 12.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Creatinine

RESULT: 2.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Glucose

RESULT: 100

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Electrolytes

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Calcium

RESULT: 9.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Phosphorus

RESULT: 3.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Serum Bilirubin

RESULT: 1.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Alkaline Phosphatase

RESULT: 100

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Aspartate Aminotransferase

RESULT: 10

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Alanine Aminotransferase

RESULT: 10

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Lactate Dehydrogenase

RESULT: 1000

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Prothrombin Time

RESULT: 12.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Partial Thromboplastin Time

RESULT: 30.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Fibrinogen

RESULT: 300

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: D-Dimer

RESULT: 0.5

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Hemoglobin

RESULT: 12.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Hematocrit

RESULT: 35.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Red Blood Cell Count

RESULT: 4.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: White Blood Cell Count

RESULT: 10.0

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Differential White Blood Cell Count

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Platelet Count

RESULT: 150,000

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Urinalysis

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Stool Analysis

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Sputum Analysis

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: CSF Analysis

RESULT:

REMARKS:

LABORATORY REPORT

DATE: 12/15/63

TIME: 10:00

TEST: Other Tests

RESULT:

REMARKS:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Annie R. Phillips			2a. DATE OF DEATH MONTH DAY YEAR December 19, 1983		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH 7TH 16^{AY} 00^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wyman Park Health Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST - - -			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Powell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-09-5986		17. INFORMANT ADDRESS Harold Phillips 311 N. Payson St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole 5520 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration / Hypoxia (c) Repair of Strangulated R Femoral Hernia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min 30 min 13 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension Probable CAD					
19a. DATE OF OPERATION 12/18		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Strangulated R Femoral Hernia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 83 , to 12/19 , 19 83 , that (I) (we) last saw the deceased alive on 12/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marrone				22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marrone				22e. ADDRESS WYMAN PARK	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA	
23d. LOCATION (CITY OR TOWN) Owings Mills		23e. COUNTY MD		23f. STATE MD	

24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 21 1983	
				25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DOROTHY Lee PHILLIPS				December 19, 1983				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		60 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		6113 Bessemer Ave.		Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6113 Bessemer Avenue 21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
John W. Randall		Minnie Shinholtz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		218-16-4919		John F. Phillips		6113 Bessemer Avenue Balto., MD. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Metastatic Ca. Breast DUE TO, OR AS A CONSEQUENCE OF (b) Ca. Breast DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				NIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/15/83 to 12/12/83, that (I) (we) last saw the deceased alive on 12/12/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Seymour Weiner, M.D.		22c. DATE SIGNED 12/19/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		1900 E. Northern Parkway							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/23/83		Oak Lawn		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Duda-Ruck Funeral Home of Dundalk, Inc.		7922 Wise Ave.		DEC 21 1983					

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examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

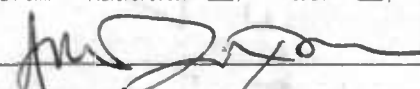
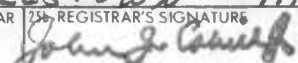
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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) INEZ						FIRST MIDDLE LAST PHILLIPS						2a. DATE KNOWN OF DEATH OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-2-83 19						2b. HOUR M 9:30A			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 06 40		6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YR. MONTHS DAYS 73		IF UNDER 24 HRS. HOURS MIN. 19		2c. DATE PRONOUNCED DEAD 12-2-83 19				2d. HOUR M 9:30A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City						MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3704 Fairview Avenue (rear)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13b. STREET ADDRESS 21216 3704 FAIRVIEW AV.									
13a. STATE md.		13b. COUNTY		13c. CITY OR TOWN BALTO.		14. FATHER'S NAME FIRST MIDDLE LAST ISAAC PHILLIPS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH BLACK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS JULIA FALLARD 501 POPLAR GROVE ST. 21223													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stabwounds of chest 966D Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a:																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-2-83 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject found stabbed													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in the rear of				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3704 Fairview Ave. Baltimore, Maryland													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12-2-83							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PARK						23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN md.									
24. FUNERAL DIRECTOR NAME ADDRESS Redd Funeral Home - 5209 YORK RD. 21212				25a. DATE REC'D. BY REGISTRAR DEC 9 1983														25b. REGISTRAR'S SIGNATURE 			

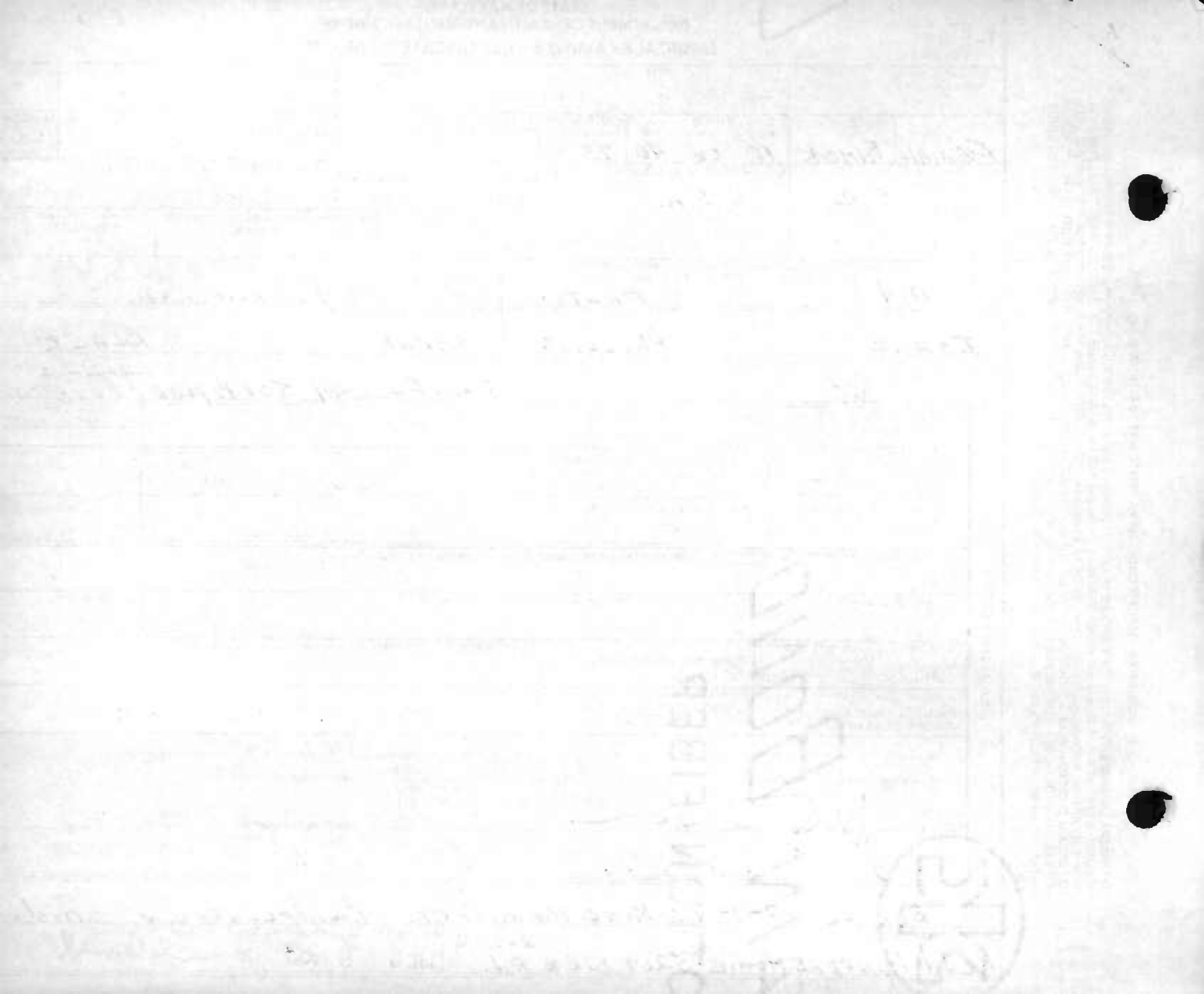
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN TO MEDICAL EXAMINER, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP.

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(VR A15 ME (5))
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES PHILLIPS				2a. DATE OF DEATH MONTH DAY YEAR 12-31-83			
3. SEX MALE				2b. HOUR 12⁰³ P.M.			
4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2-3-02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? UNKNOWN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10. CITY OR TOWN OF DEATH BALT. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN L. DEATON MED. CTR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY DELIVERY of fuen.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY BALT.			
13c. CITY OR TOWN BALT.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN		17. INFORMANT Lenore Jenkins			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5070 DUE TO, OR AS A CONSEQUENCE OF (b). possible aspiration pneumonia infected decubitus DUE TO, OR AS A CONSEQUENCE OF (c). nebbis		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I (this hospital) attended the deceased from Dec 12 , 19 83 , to Dec 31 , 19 83 , that (I (we) lost saw the deceased alive on Dec 23 , 19 83 , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above (I (we) (did) (did not) view the body after death.	
22b. SIGNATURE Wendy Kloesz		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendy Kloesz		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (5) BURIAL		23b. DATE 1/14/84	
23c. NAME OF CEMETERY OR CREMATORY Eastview MEM. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JAN 13 1984	
25b. REGISTRAR'S SIGNATURE Sam J. Amiel							

BP

1. NAME OF THE PERSON OR ORGANIZATION		2. ADDRESS	
3. CITY AND STATE		4. ZIP CODE	
5. TITLE OF THE DOCUMENT			
6. DATE OF THE DOCUMENT			
7. NAME OF THE AUTHOR			
8. NAME OF THE ORGANIZATION			
9. NAME OF THE PROJECT			
10. NAME OF THE SPONSOR			
11. NAME OF THE REVIEWER			
12. NAME OF THE APPROVER			
13. NAME OF THE DISTRIBUTOR			
14. NAME OF THE RECIPIENT			
15. NAME OF THE DONOR			
16. NAME OF THE BENEFACTOR			
17. NAME OF THE GRANTEE			
18. NAME OF THE AWARD			
19. NAME OF THE PRIZE			
20. NAME OF THE MEDAL			
21. NAME OF THE DIPLOMA			
22. NAME OF THE CERTIFICATE			
23. NAME OF THE LETTER			
24. NAME OF THE MEMO			
25. NAME OF THE REPORT			
26. NAME OF THE STUDY			
27. NAME OF THE ANALYSIS			
28. NAME OF THE EVALUATION			
29. NAME OF THE ASSESSMENT			
30. NAME OF THE REVIEW			
31. NAME OF THE INSPECTION			
32. NAME OF THE AUDIT			
33. NAME OF THE SURVEY			
34. NAME OF THE POLL			
35. NAME OF THE VOTE			
36. NAME OF THE ELECTION			
37. NAME OF THE CAMPAIGN			
38. NAME OF THE ISSUE			
39. NAME OF THE TOPIC			
40. NAME OF THE SUBJECT			
41. NAME OF THE FIELD			
42. NAME OF THE AREA			
43. NAME OF THE REGION			
44. NAME OF THE COUNTRY			
45. NAME OF THE CONTINENT			
46. NAME OF THE OCEAN			
47. NAME OF THE SEA			
48. NAME OF THE LAKE			
49. NAME OF THE RIVER			
50. NAME OF THE MOUNTAIN			
51. NAME OF THE HILL			
52. NAME OF THE VALLEY			
53. NAME OF THE PLAIN			
54. NAME OF THE DESERT			
55. NAME OF THE TROPIC			
56. NAME OF THE EQUATOR			
57. NAME OF THE POLE			
58. NAME OF THE AXIS			
59. NAME OF THE ORBIT			
60. NAME OF THE PERIOD			
61. NAME OF THE YEAR			
62. NAME OF THE MONTH			
63. NAME OF THE DAY			
64. NAME OF THE HOUR			
65. NAME OF THE MINUTE			
66. NAME OF THE SECOND			
67. NAME OF THE MILLISECOND			
68. NAME OF THE MICROSECOND			
69. NAME OF THE NANOSECOND			
70. NAME OF THE PICOSECOND			
71. NAME OF THE FEMTOSECOND			
72. NAME OF THE ATTOSECOND			
73. NAME OF THE ZEPTOSECOND			
74. NAME OF THE YOKTOSECOND			
75. NAME OF THE SEPTOSECOND			
76. NAME OF THE OCTOSECOND			
77. NAME OF THE NONOSECOND			
78. NAME OF THE DECASECOND			
79. NAME OF THE HECTOSECOND			
80. NAME OF THE KILLOSECOND			
81. NAME OF THE MEGASECOND			
82. NAME OF THE GIGASECOND			
83. NAME OF THE TERASECOND			
84. NAME OF THE PETASECOND			
85. NAME OF THE EXASECOND			
86. NAME OF THE ZETASECOND			
87. NAME OF THE YOTTASECOND			
88. NAME OF THE RONTASECOND			
89. NAME OF THE QUECTASECOND			
90. NAME OF THE SEPTOSECOND			
91. NAME OF THE OCTOSECOND			
92. NAME OF THE NONOSECOND			
93. NAME OF THE DECASECOND			
94. NAME OF THE HECTOSECOND			
95. NAME OF THE KILLOSECOND			
96. NAME OF THE MEGASECOND			
97. NAME OF THE GIGASECOND			
98. NAME OF THE TERASECOND			
99. NAME OF THE PETASECOND			
100. NAME OF THE EXASECOND			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

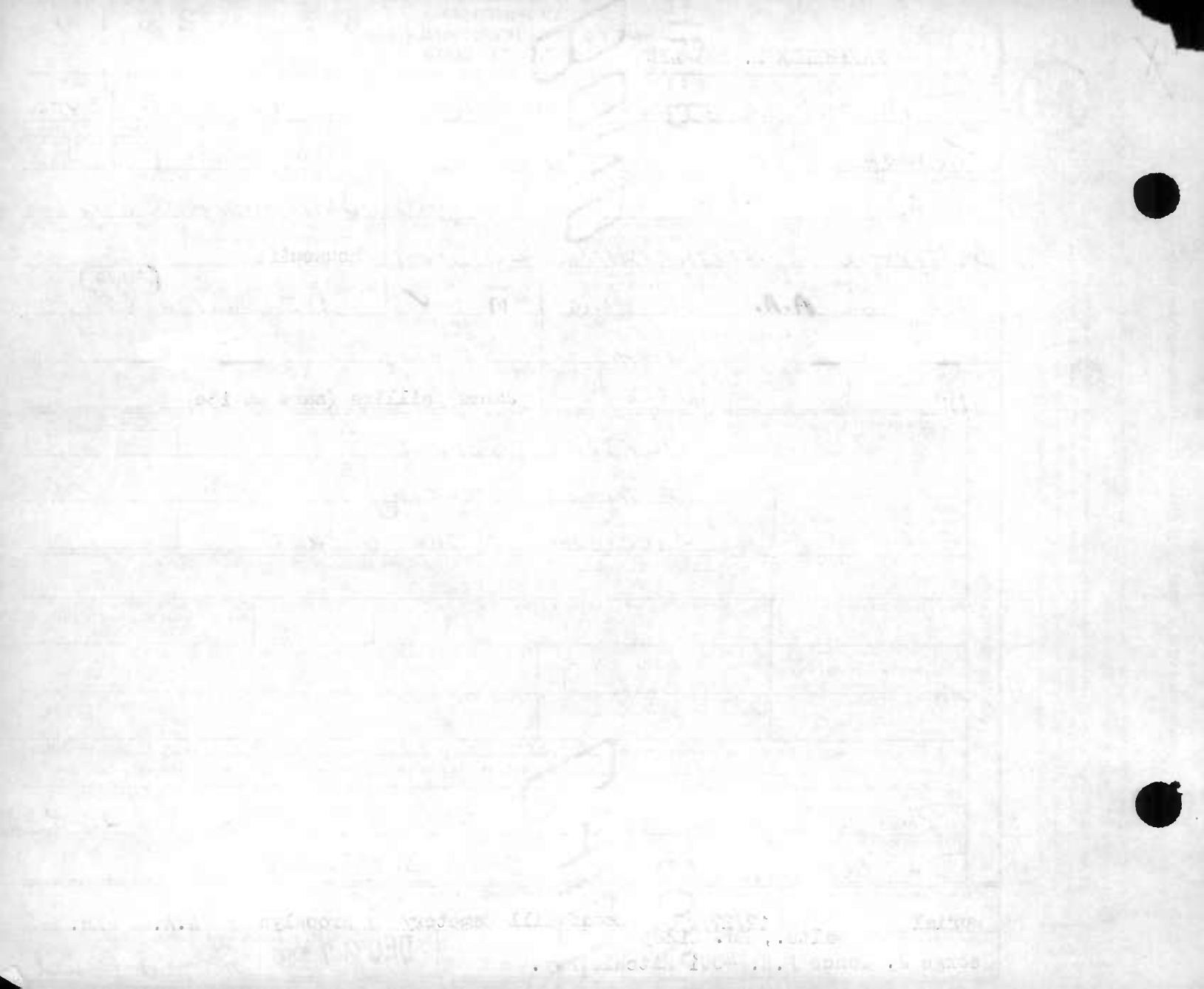
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR MARYBELLE L. PHILLIPS				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marybelle Louise Phillips				2b. HOUR 7:45 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6-15-35		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Riley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily		13e. STREET ADDRESS / ZIP CODE 185 Dunlap Rd (21122)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-30-7928		17. INFORMANT James Phillips (same as 13e)		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Internal Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the breast PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 83 , to 12-23 , 19 83 , that (I) (we) last saw the deceased alive on 12-23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rhonda Richards, M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-23-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Berkman				22e. ADDRESS 3001 S. Hanover			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Conish	
ADDRESS F.H. 4001 Ritchie Hwy.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CORA - E. Philmore			2a. DATE OF DEATH MONTH DAY YEAR 12-27-83		2b. HOUR 7AM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 1 28 04	6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH City, BALTO MD			
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE Sq. Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY unknown	
13a. STATE md		13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2847 CARVER Rd. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST -			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-22-9777		17. INFORMANT ADDRESS Thomas Philmore 2847 Carver Road		
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCD - atrial fibrillation 4148 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 1 year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Sacral Abscesses, (2) AKA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 936 W. NORTH RD. BALTO MD 21217		
22a. I certify that (this hospital) attended the deceased from 12-16- 19 83 , to 12-27- 19 83 , that (we) last saw the deceased alive on 12-27-83 19 83 , and that in (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)						

MEDICAL CERTIFICATION

BP

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR
NAME Wm C March F/H Inc. 1101 E North Avenue ADDRESS

DEC 28 1983

John J. Connel

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32812	
1. DECEASED NAME (TYPE OR PRINT) James J. Pierce										2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 12/4/83 19											
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 20 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		7c. DATE PRONOUNCED DEAD 12/4/83 19 P									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3220 Avon Avenue												12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3154 Ellerslie Avenue		21218			
14. FATHER'S NAME FIRST MIDDLE LAST - - -										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - -											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Evelena Frisby 3640 Ellerslie Ave.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12/5/83							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk, Arbutus,				23d. LOCATION CITY OR TOWN COUNTY STATE Md.											
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.				ADDRESS 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 9 1983				25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>									

DEC 20 1950

RECEIVED

NOV 20 1950

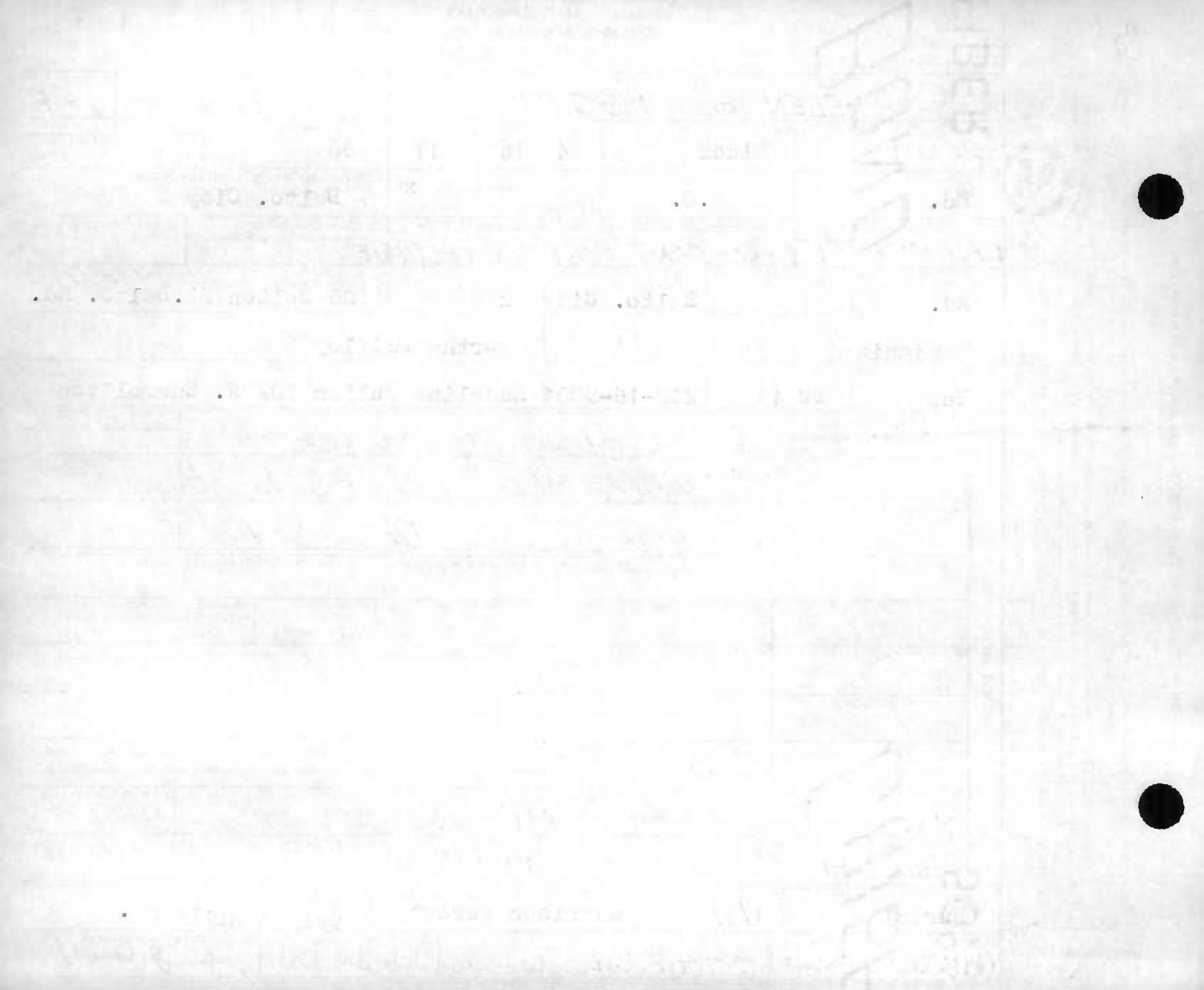
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
HELEN B PIGOTT		12 27 83				24 5 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		Black		4 16 17		66		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Md.		U.S.				Balto. City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE CITY		PROVIDENT HOSPITAL BALTIMORE							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.				Balto. City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 Bolton St. Balto. Md.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Benjamin				Bertha Faidley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		WW 11		212-16-9001 Madeline Pullen 702 N. Carrollton					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>cardiogenic shock</u>									
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>Hypertension Diabetes Mellitus</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-13-83</u> to <u>12-27-83</u> , that (I) (we) last saw the deceased alive on <u>12-27-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
SHER APZAL HASHMI					MD		12-27-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
SHER APZAL HASHMI					PROVIDENT HOSPITAL BALTIMORE				
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		1/3/84		Garrison Forest		OWINGS Mills Md.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. W. C. WRIGHT 2700 Edmondson Ave					DEC 29 1983		John J. Connel		

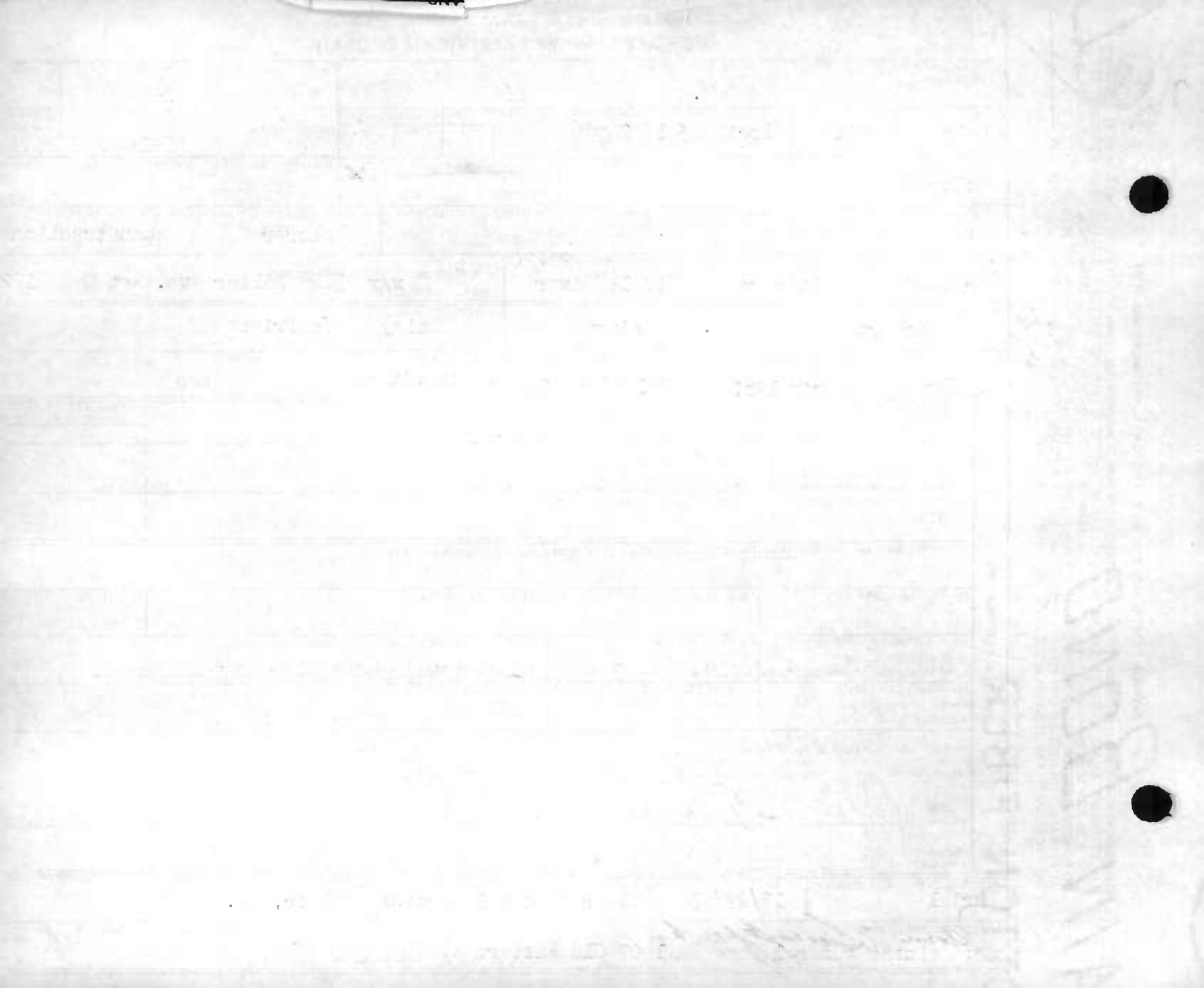


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32814	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Guy M. Pitman										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-24 19 83	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YRS. April 25 1957	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 28	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 12-24 19 83	7d. HOUR 5:17 a.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland										13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS 5228 Miller Ave. Apt D 2122
14. FATHER'S NAME FIRST MIDDLE LAST Robert M. Pitman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Jeffries							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 231 88 4427		17. INFORMANT James Pitman		17. ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 6:10 a.m. 12-23 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in auto/fixed object impact					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Andre & McComas St., Balto., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12-24-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Belair, Md.				
24. FUNERAL DIRECTOR Przedzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE John J. Connel					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8 3 3 2 8 1 5					
1. DECEASED NAME (TYPE OR PRINT) REV. Dr. <u>WILLIAM</u> <u>Lyndsai</u> <u>PITTS</u> Sr.				2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> <u>17</u> <u>83</u>		2b. HOUR <u>5:27</u> AM			
3. SEX <u>Male</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10</u> <u>18</u> <u>12</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CITY</u> MD.			
10. CITY OR TOWN OF DEATH <u>BALTO. CITY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>PROVIDENT HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>718 Dolphin Street 21217</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William</u> <u>A.</u> <u>Pitts</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lettie</u> <u>G.</u> <u>Washington</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT ADDRESS <u>Brenda Haynes 5111 Greenwich Avenue</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> <u>4329</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRACRANIAL BLEED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>83</u> , to <u>12/17</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/17/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John E. Gordon</u> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/17/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN E GORDON MD</u>				22e. ADDRESS <u>2600 Liberty Hgts</u>					
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>12/21/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>		23d. LOCATION <u>Arbutus</u>		COUNTY <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Wm C March F/H Inc. 1101</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

INDEX



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8401 30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jared Mitchell Poist			2a. DATE OF DEATH MONTH DAY YEAR 12 25 83			2b. HOUR 4:25 PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 14 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS — 0 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —	
13a. STATE Md		13b. CITY OR TOWN Randallstown		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 3708 Trent Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Allen Poist				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melanie Horton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Mr. & Mrs. Allen Poist 21133 3708 Trent Road Randallstown, MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) cardiorespiratory arrest

7762

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypoxia Pulmonary hemorrhage

5h

DUE TO, OR AS A CONSEQUENCE OF

(c) D.F.C. 2° Hypothermia +/- sepsis

5h

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —			
22a. I certify that (I) (this hospital) attended the deceased from <u>11 AM 12/25</u> , 19 <u>83</u> , to <u>4:25 PM - 12/25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4 PM 12/25</u> , 19 <u>83</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Paul H Lipkin</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/25/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL H LIPKIN		22e. ADDRESS Sinai Hospital Baltimore, Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-83		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR DEC 27 1983			
				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified of choice.

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. DETAIN PAGE 5. PAGES 1, 2, AND 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AND 3 SHOULD BE FILED, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John V. Pollard, Jr.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 5 YEAR 1983	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH FEB. DAY 18 YEAR 1971	6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 12 5 19 83		2d. HOUR 8:15P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL			
13a. STATE MD.			13b. COUNTY B. Co.		13c. CITY OR TOWN CAP. HGTS.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 509 62nd PL.		
14. FATHER'S NAME FIRST JOHN MIDDLE V. LAST POLLARD, SR.				15. MOTHER'S MAIDEN NAME FIRST BOBBIE D. MIDDLE BESS LAST BESS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS JOHN V. POLLARD, SR. - SAME AS #13 ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound to head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 8:40 MIN. 12 P.M. DAY 2 YEAR 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 509 62nd Place CITY OR TOWN Capitol Hgts, P.G. Co, Md. COUNTY STATE 						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12/6/83				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto., MD.								
22b. BURIAL, CREMATION, REMOVAL (SPECIFY)			22b. DATE 12/8/83		22c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		22d. LOCATION CITY OR TOWN HIGHCHAND PARK COUNTY A.G. STATE MD.				
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS ADDRESS 4925 BURRHOUGH AVE., N.E.					25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Church</i>				



MAIL BOXES FOR 1911

NO.

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DATE OF MAIL BOX

NAME OF MAIL BOX

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Clyde L. Portee</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-20-83</i>		2b. HOUR <i>8:51 AM</i>	
3. SEX <i>male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08-05-12</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore General</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Chester</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agnes (Hawkins)</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218-07-5572</i>		17. INFORMANT ADDRESS <i>Shirley P. Page 3614 Mohawk Avenue</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>						
1629						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
(b) <i>Respiratory Arrest</i>						
DUE TO, OR AS A CONSEQUENCE OF						
(c) <i>Oat Cell Carcinoma of the lung, metastatic</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Massive pneumonia, lower lobe, R. lung.</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Richard Richards, M.D.</i>		DEGREE		22c. DATE SIGNED <i>12-20-83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Ronite</i>		22e. ADDRESS <i>3001 S. Hanover</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>12/24/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Mem Pk.</i>		
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H, Inc.</i>		ADDRESS <i>1101 E. North Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 22 1983</i>		
				25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CONFIDENTIAL
EXCLUDED FROM AUTOMATIC
DOWNGRADING AND
DECLASSIFICATION

SECRET
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(M)

[Faint, mostly illegible handwritten text covering the majority of the page]

SECRET

CONFIDENTIAL

DEC 8 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR Mary F. Ports				2a. DATE OF DEATH MONTH DAY YEAR 12 19 1983			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary F. Ports				2b. HOUR 4 ⁴⁰ / _{PM}			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 03 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan 21239		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)		13e. STREET ADDRESS 3333 Paine Street 21211			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-5525		17. INFORMANT ADDRESS Jim Ports 5 Whitelaw Place Apt TC 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 Cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION 12/8 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured viscus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE CHUNG CHU NG				DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHUNG CHU NG				22e. ADDRESS Good Samaritan Hospital.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY Park Wood Cemetery		23d. LOCATION CITY OR TOWN COUNTY Baltimore Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32820	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Wesley Ports						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 2 YEAR 1983				2b. HOUR 5:56 M A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 7, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4711 Norwood Avenue 21207				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed Electrician			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4711 Norwood Avenue 21207			
14. FATHER'S NAME Walter Ports						15. MOTHER'S MAIDEN NAME Daisy Gertrude Hissey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-03-0447		17. INFORMANT Mrs. Isobel Meyer ADDRESS 21239 1500 Regester Avenue Baltimore, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER				DATE SIGNED 12/3/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-6-83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Maryland			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, INC. ADDRESS 8728 Liberty Road Randallstown Md. 21133						25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Grieb			



AMERICAN STATE

AMERICAN STATE

AMERICAN STATE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32821	
1. DECEASED NAME (TYPE OR PRINT) Joseph F. Posluszny										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12-6 19 83	
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11-25-1921	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 12-6 19 83	2d. HOUR 11:55 P. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELEC.		12b. KIND OF BUSINESS OR INDUSTRY MARYLAND DRY DOCK			
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21224 1025 S. CURLEY ST.			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK POSLUSZNY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA SAS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 217-18-9627		17. INFORMANT ADDRESS DOROTHY E. POSLUSZNY 21224 SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12-7-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-10-83		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MD.			
24. FUNERAL DIRECTOR NAME THOMAS J. SKARDA ADDRESS 2829 HUDSON ST.				25a. DATE REC'D. BY REGISTRAR DEC 9 1983				25b. REGISTRAR'S SIGNATURE John J. Carrick			

BP

1914
To the Honorable
The Secretary of Agriculture
Washington, D. C.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed establishment of a new plant industry in the State of California.

RECEIVED

NOV 10 1914



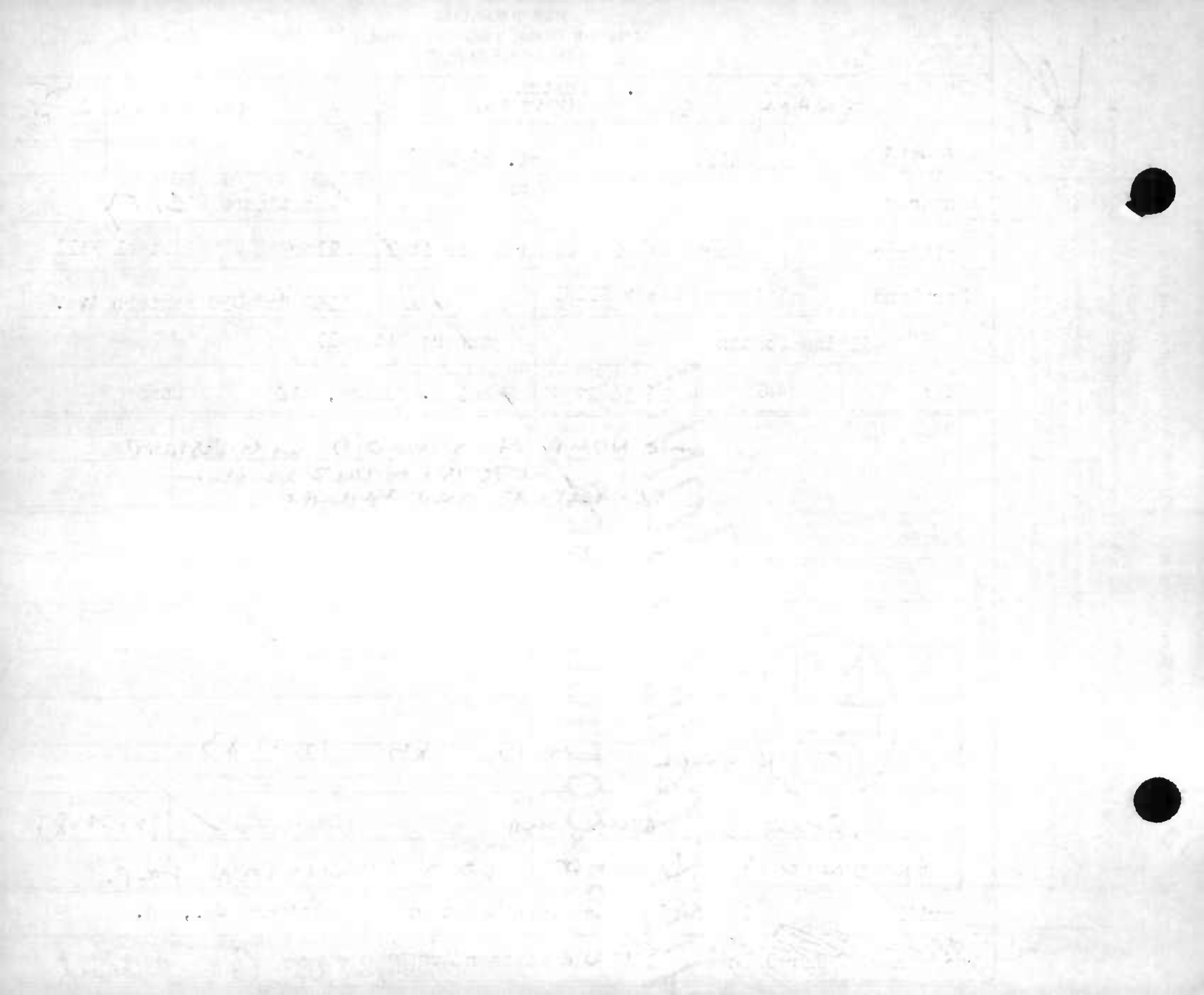
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8332822					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 12 22 83				2b. HOUR 2 P.M.	
3. DECEASED NAME (TYPE OR PRINT) Frank S. Poston					4. SEX MALE				5. RACE White	
6. DATE OF BIRTH MONTH DAY YEAR Oct. 22 1896					7. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.				8. IF UNDER 1 YEAR MONTHS DAYS	
9. BIRTHPLACE (STATE OR FOREIGN) Kentucky					10. CITIZEN OF WHAT COUNTRY? USA				11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. CITY OR TOWN OF DEATH Baltimore					13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland 15b. COUNTY Baltimore 15c. CITY OR TOWN Essex 21221					16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				17. STREET ADDRESS 1107 "B" Old Eastern Ave. 21201	
18. FATHER'S NAME FIRST William Poston MIDDLE LAST					19. MOTHER'S MAIDEN NAME Barbara Mitchell MIDDLE LAST				20. ADDRESS Same	
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					21b. SOCIAL SECURITY NO. 216 10 2759				21c. INFORMANT Mabel M. Poston, Wife	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF SIGMOID in WIDESPREAD METASTASIS TO LUNG & LIVER 1533 (b) CONGESTIVE HEART FAILURE (c) DUE TO, OR AS A CONSEQUENCE OF					23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
24a. DATE OF OPERATION					24b. CONDITION FOR WHICH OPERATION WAS PERFORMED				24c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
26a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				26c. LOCATION STREET CITY OR TOWN COUNTY STATE	
27. I certify that (I) (this hospital) attended the deceased from 12-13 1983, to 12-22-83, 1983, that (I) (we) last saw the deceased alive on 12-22-83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
28a. SIGNATURE Antonio S. Ravidia					28b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				28c. DATE SIGNED 12-22-83	
29a. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO S. RAVIDA					29b. ADDRESS NORTH CHARLES GEN. HOSP.					
30a. BURIAL, CREMATION, REMOVAL Burial					30b. DATE 12/26/83				30c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
31a. LOCATION Baltimore Co., Md.					31b. STATE					
32. FUNERAL DIRECTOR (NAME) Pruzdzinski Funeral Home PA 1407 Old Eastern Ave					33. DATE REC'D. BY REGISTRAR DEC 23 1983				34. REGISTRAR'S SIGNATURE John J. Connel	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Saloma <i>Saloma</i>			2a. DATE OF DEATH MONTH 12 DAY 11 YEAR 1983			2b. HOUR 10:45 M								
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 10 DAY 3 YEAR 21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS — DAYS —		8. IF UNDER 74 HRS HOURS — MIN. —				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21215 3914 Ridgewood Ave		
14. FATHER'S NAME FIRST John MIDDLE Lyles LAST Lyles				15. MOTHER'S MAIDEN NAME FIRST Saloma MIDDLE Preston LAST Preston										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Alfred G. Powell 3914 Ridgewood Ave.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Metastatic Breast Cancer****1749**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Anemia **Dehydration**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/11 , 19 83 , to 12/11 , 19 83 , that (I) (we) last saw the deceased alive on 12/11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE RE Perry, MD				DEGREE MD		22c. DATE SIGNED 12/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RE Perry MD				22e. ADDRESS Sinai Hosp Baltimore MD 21205			
23a. BURIAL, CREMATION, REMOVAL (15b)		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA Owing Mills, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	

24. FUNERAL DIRECTOR

Wm C March F/H Inc. 1101 E North Avenue

25a. DATE REC'D. BY REGISTRAR

DEC 13 1983

25b. REGISTRAR'S SIGNATURE

Am J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVA K. PRICE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1983		2b. HOUR 1900 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 25 1894	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dining Room Oper.-Self Emp.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY BALTO.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3925 Beech Ave. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Elijah Fletcher Kahle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Gillet			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-24-9774		17. INFORMANT ADDRESS Bradley Mettee Catonsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>(R) HIP FRACTURE, CONGESTIVE HEART FAILURE, HYPERTENSION, Hx HYPERTHYROIDISM</u>					
19a. DATE OF OPERATION 12/4/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED (R) HIP		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR ? P.M. 12 3 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) FELL GETTING OUT OF BED	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) O		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3925 BEECH AVE 21207 BALT. MD	
22a. I certify that (this hospital) attended the deceased from <u>12/3</u> , 19 <u>83</u> to <u>12/8</u> , 19 <u>83</u> , that (we) last saw the deceased alive on <u>12/8</u> , 19 <u>83</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Peter G. Wallace</u> MD				22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER G WALLICE MD				22e. ADDRESS UNION MEMORIAL HOSPITAL 201 E UNIVERSITY AVE BALT MD 21218	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-10-83		23c. NAME OF CEMETERY OR CREMATORY Green Mount	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR DEC 13 1983			
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.				25. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



Information obtained by Special Agent

Creation: 11/10/92
Greenwood
Harry W. Jackson & Sons Co., Inc., Inc.
11/10/92

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

Film G588

FOR Item # 5,6,7b, 13b 16a DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE REGISTRAR 2-7-84 rja b
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Price			2a. DATE OF DEATH MONTH 12 DAY 05 YEAR 83			2b. HOUR M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 8 DAY 10 YEAR 1988		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1701 Eutaw Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1701 Eutaw Place 21217			
14. FATHER'S NAME FIRST Eugene MIDDLE Price LAST				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Richardson LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) W.W. I		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-09-6045		17. INFORMANT ADDRESS Eugene Price Jr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniel J. Winn				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel J. Winn				22e. ADDRESS 8842 Belair Road Perry Hall Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE 21238			
24. FUNERAL DIRECTOR NAME The Bailey Funeral Home ADDRESS 1348 N. Calhoun St.				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carver					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Henrietta G. Price					2a. DATE OF DEATH MONTH DAY YEAR 12 8 83			2b. HOUR 10:45^a M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 5 87		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director		12b. KIND OF BUSINESS OR INDUSTRY Therapy		
13a. STATE Md.					13b. COUNTY Towson		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John C. George					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annabel Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.			16b. SOCIAL SECURITY NO. 212-32-1424		17 INFORMANT ADDRESS 1121 Hollingsworth Joppa Md. 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic CVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
DUE TO, OR AS A CONSEQUENCE OF (b) _____								Term. episode 4 days		
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9 Feb , 19 81 , to 5 Dec , 19 83 , that (I) (we) lost saw the deceased alive on 8 Dec , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Harold P. Briebe MD					DEGREE MD			22c. DATE SIGNED 8 Dec 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/8/83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Anatomy Board					25. DATE DEC. BY REGISTRAR DEC 19 1983					
26. REGISTRAR'S SIGNATURE John J. Canine					27. REGISTRAR'S SIGNATURE John J. Canine					

Received 12/10/83

John	C.	George	Donald	Lee
Unknown	212-32-1024	Mr. Charles Dalton	1127 Hollinsworth	1127 Hollinsworth

Hd.	Town	TO RICHMOND ROAD	3700A
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Natic City	U.S.	Director	Therapy
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Female	Male	Police
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) BABY GIRL PROCTOR		2a. DATE OF DEATH MONTH DAY YEAR 9 - 15 - 83		2b. HOUR 4:45 AM	
3. SEX FEMALE		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9 14 83		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 9 35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD.		13b. CITY OR TOWN WALDORF		13c. STREET ADDRESS Rt 2 Box 195A WALDORF MD 20682		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHAS WALTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ty rise PROCTOR		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	
17. INFORMANT ADDRESS							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC - RESP FAILURE**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PREMATURITY - HMD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/15/83 , 19 83 , to 9/15/83 , 19 83 , that (I) (we) last saw the deceased alive on 9/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Matthew Stearns M.D.				DEGREE M.D.		22c. DATE SIGNED 9/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Sinai Hospital of Baltimore		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-28-83		23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24. FUNERAL DIRECTOR NAME SINAI Hospital				ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	
						25b. REGISTRAR'S SIGNATURE John J. Conner	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 8 2 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTOINE (ANTRON) PUMPHREY										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12-9-83 19	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 24 78		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 5		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 12-9-83 19	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 		12b. KIND OF BUSINESS OR INDUSTRY 	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leon Edward Pumphrey										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Fisher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Gladys Fisher 4108 Woodridge Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 89.02										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 12:45AM 12-9-83				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:45AM 12-9-83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION CITY OR TOWN STATE 1116 N. Monroe St. Baltimore, Md. MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						25a. DATE REC'D. BY REGISTRAR DEC 12 1983					
ADDRESS 1101 E. North Ave.						REGISTRAR'S SIGNATURE <i>John J. Calver</i>					

OFFICE OF THE SECRETARY OF THE ARMY

ARMY OFFICE

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(14)
14

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

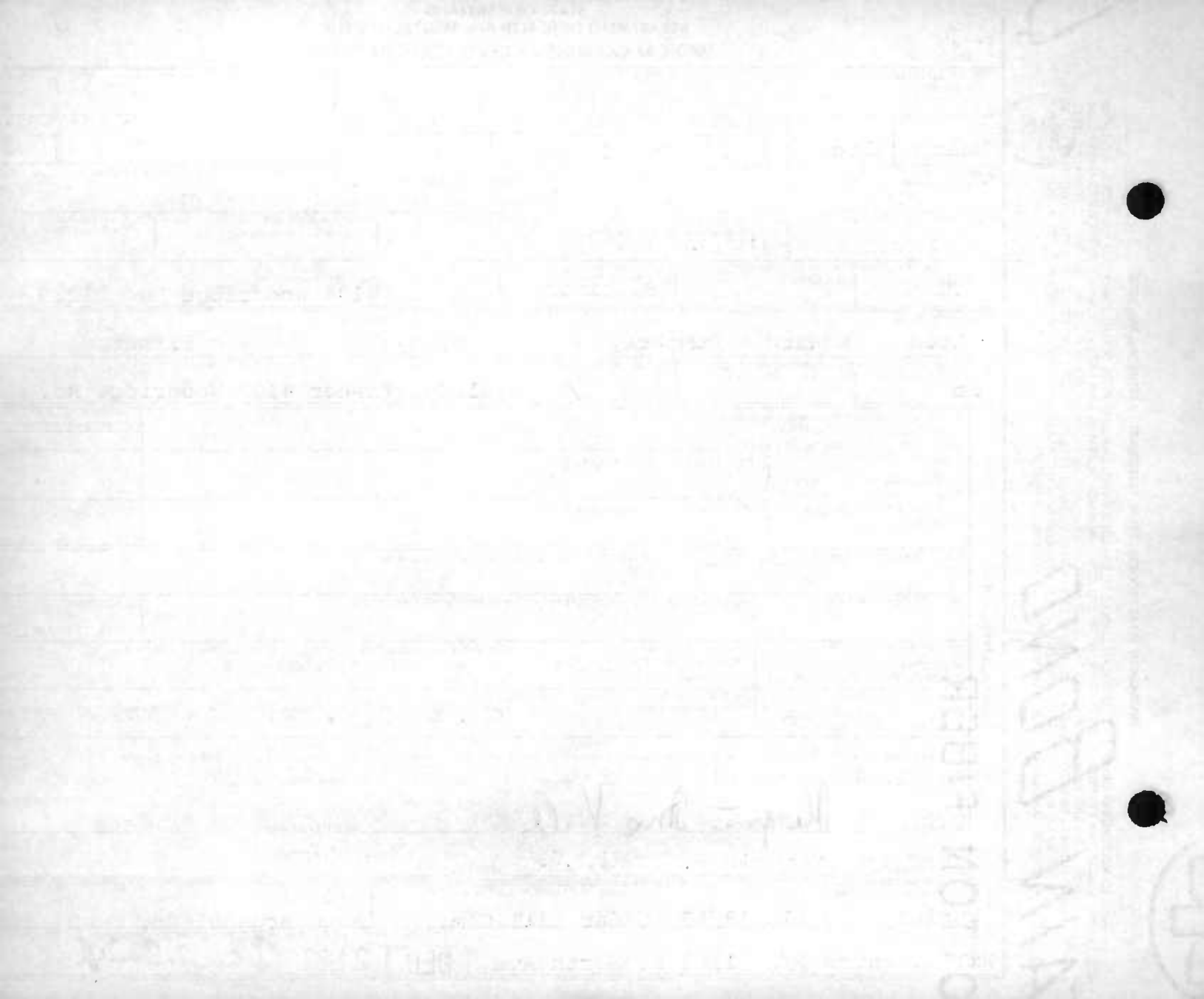
31- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST ANTONIO			MIDDLE E.			LAST (FISHER) PUMPHREY			2a. DATE OF DEATH KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 12-9-83 <input type="checkbox"/> 19			2b. HOUR M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 26 79		6. AGE (IN YEARS) LAST BIRTHDAY 4 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12-9-83 19			2d. HOUR 11AM M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4108 Woodridge Rd. 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Leon Edward Pumphrey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Fisher													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. N/A						17. INFORMANT ADDRESS Gladys Fisher 4108 Woodridge Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u> 8902 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:45AM 12-9-83 P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION 1116 N. Monroe St. Baltimore, Maryland STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Margaret A. Korell</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-9-83											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/13/83				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 12 1983											
								25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>											

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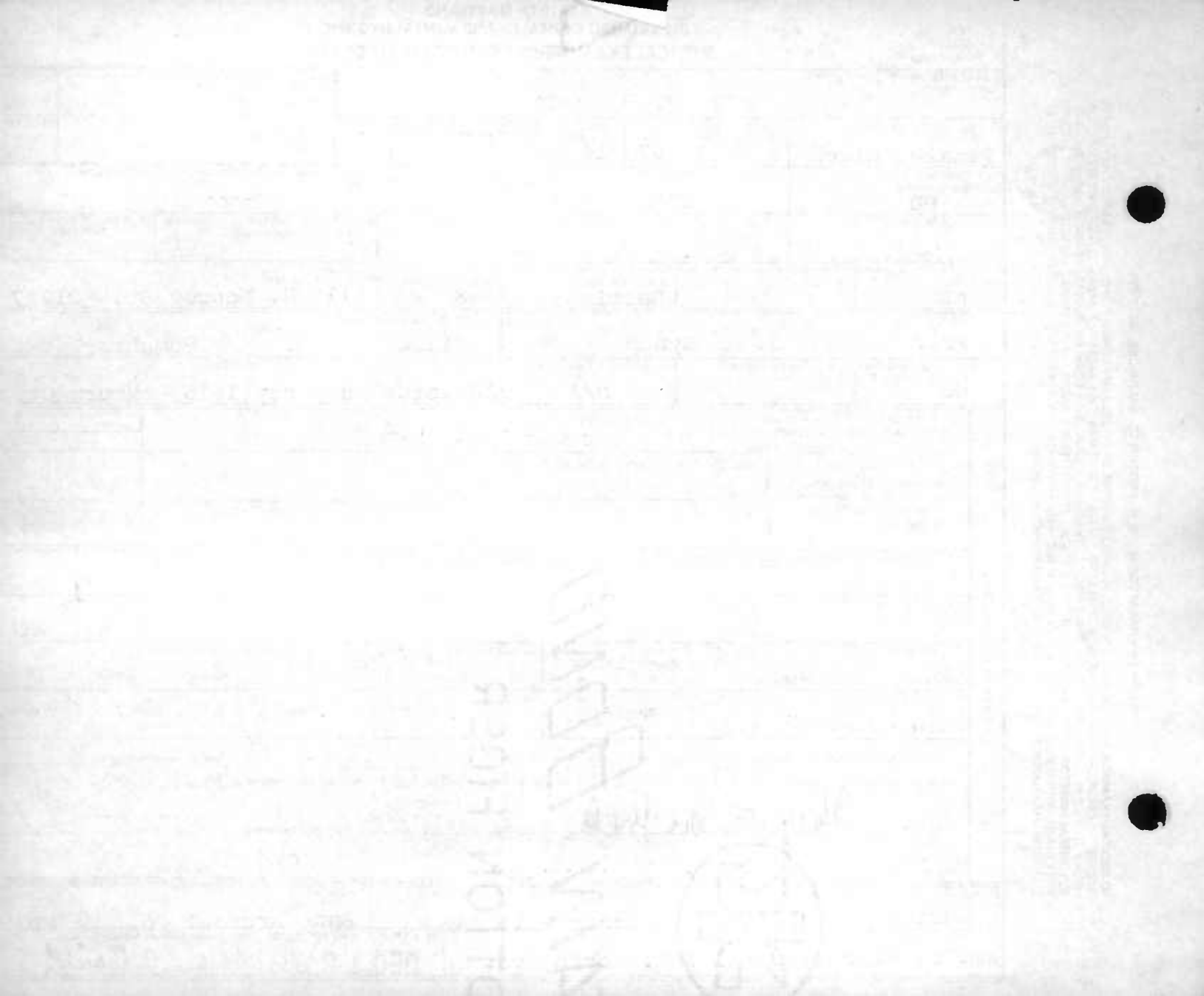
Handwritten signature or initials

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32831	
1. DECEASED NAME (TYPE OR PRINT) BERNADETTE M. PUMPHREY							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12-9-83		2b. HOUR 1AM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 1 67		6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD 12-9-83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 1116 N. Monroe St. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Fred J. Bynum						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gilda M. Pumphrey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Adelaide Pumphrey 1615 Bakbury Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 12:45AM 12-9-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) closet 3rd fl.		21f. LOCATION 1116 N. Monroe St. Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Com.				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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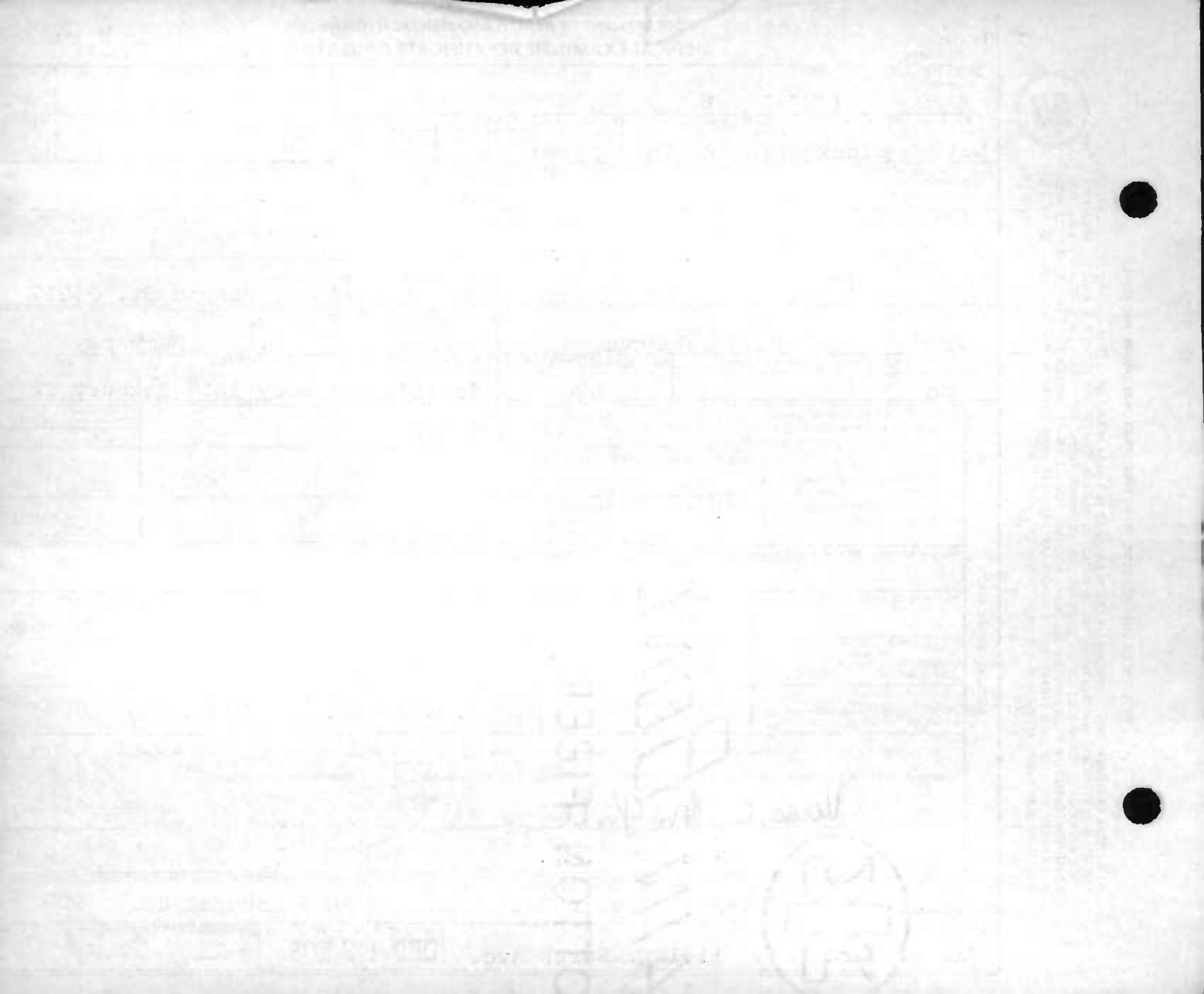
DHMH - 17
(VR A15 ME (5))
20M 4/82

3 1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRED (FREDERICK) J. PUMPHREY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-9-83 19			2b. HOUR AM			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 6 70	6. AGE (IN YEARS) LAST BIRTHDAY 13 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-9-83 19	7d. HOUR 1AM M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1116 N. Monroe St. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Fred J. Bynum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gilda M. Pumphrey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Adelaide Pumphrey 1615 Bakbury Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 12:45AM 12-9-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) caught in housefire				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1116 N. Monroe St. Baltimore, Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D BY REGISTRAR DEC 12 1983			
						25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, AND PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										3 2 8 3 3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GILDA M. PUMPHREY										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12-9-83 19	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 16 52		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 31		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-9-83 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1116 N. Monroe St. 21217			
14. FATHER'S NAME FIRST MIDDLE LAST George M. Pumphrey Jr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia M. Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Adelaide Pumphrey 1615 Bakbury Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u> 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30AM 12-9-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) caught in housefire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1116 N. Monroe St. Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margie A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

WILLIAM B. BOWEN

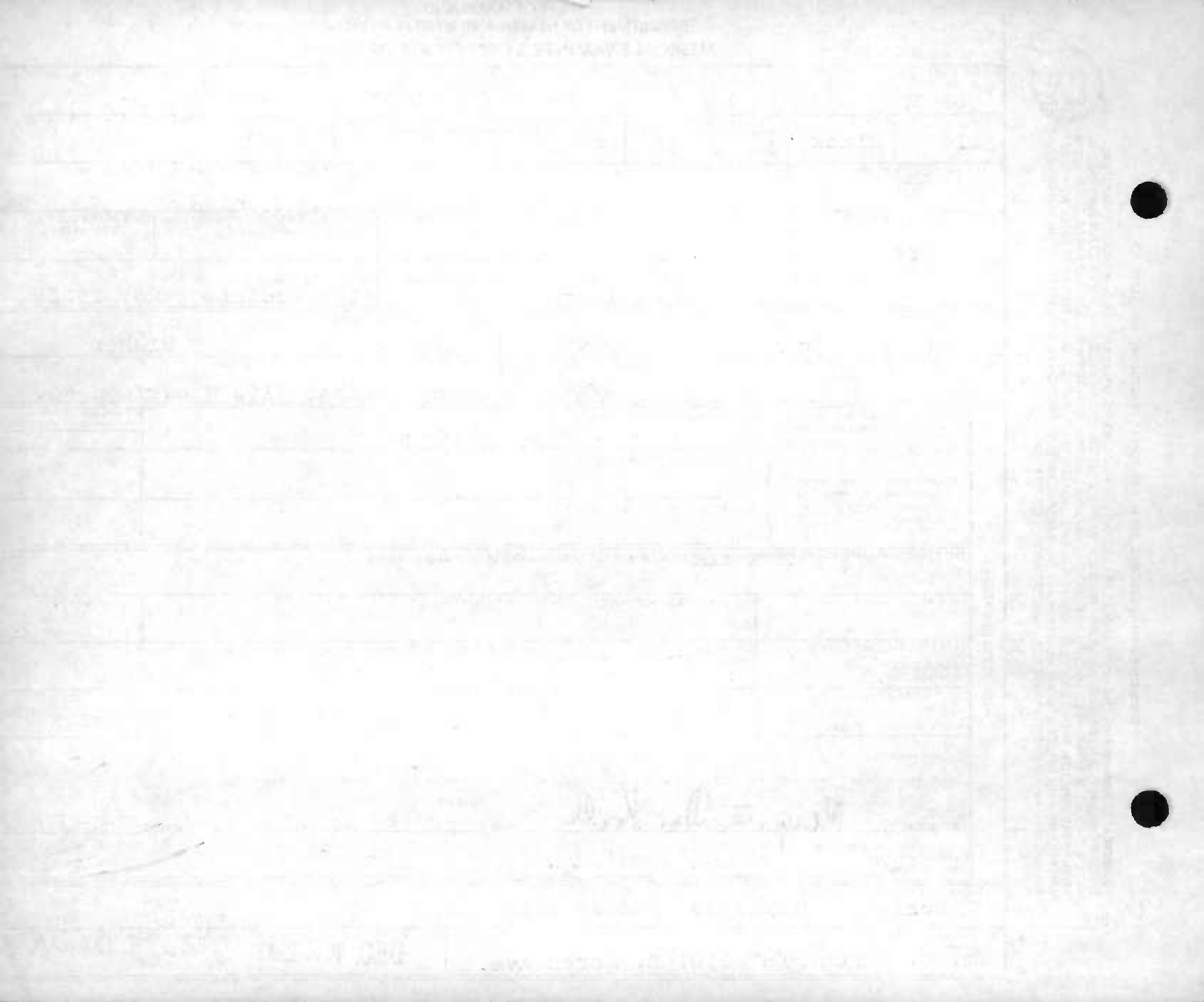
ADDITIONAL



REG. NO.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Carlton</i>			FIRST <i>Emory</i>	MIDDLE <i>Purdum</i>	2a. DATE OF DEATH MONTH <i>12</i> DAY <i>28</i> YEAR <i>83</i>			2b. HOUR <i>6:30 PM</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>10</i> DAY <i>12</i> YEAR <i>08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Church Home Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>B & O Railroad</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Rock Hall</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Rt. 1 Box 78A</i> <i>21661</i>	
14. FATHER'S NAME FIRST <i>Spencer Marsh</i> MIDDLE <i>Purdum</i> LAST <i></i>				15. MOTHER'S MAIDEN NAME FIRST <i>Lucy Clara</i> MIDDLE <i>Mullican</i> LAST <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <i>705-09-8288</i>		17. INFORMANT ADDRESS <i>Heather Lynn Purdum Rock Hall, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Shock</i> <i>4960</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Recurrent Pneumothorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic Obstructive Lung Disease, Atherosclerotic Heart Disease</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>11/10</i> 19 <i>83</i> to <i>12/28</i> 19 <i>83</i> that (I) (we) last saw the deceased alive on <i>12/28</i> 19 <i>83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Lawrence J. Appel, M.D.</i>				DEGREE		22c. DATE SIGNED <i>12/28/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence J. Appel</i>				22e. ADDRESS <i>100 N. Broadway Balto. MD 21231</i> <i>Church Home Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/31/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Chestertown, Kent, Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Tom Helfenbein</i> ADDRESS <i>Funeral Homes, Chester, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 5 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>		

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILBERT D. QUARLES			2a. DATE OF DEATH MONTH DAY YEAR 12 6 83			2b. HOUR 5 A.M.			
3 SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 9 1928		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3404 ALTO RD. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST James A. Quarles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 248971		17. INFORMANT ADDRESS Gladys J. Mitchell 2157 Chelsea Ter.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1509

IMMEDIATE CAUSE (a) Acute hemophylosis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) esophageal CA, 5/p radiation therapy.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 minutes

10 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/29, 19 83, to 12/6, 19 83, that (I) (we) lost saw the deceased alive on 12/6, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kang Sun Lee				DEGREE MD		22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KANG SUN LEE				22e. ADDRESS SINAI HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION Arbutus, COUNTY Md.	

24. FUNERAL DIRECTOR

Wm C March F/H Inc. 1101 E North Avenue

25a. DATE REC'D. BY REGISTRAR

DEC 8 - 1983

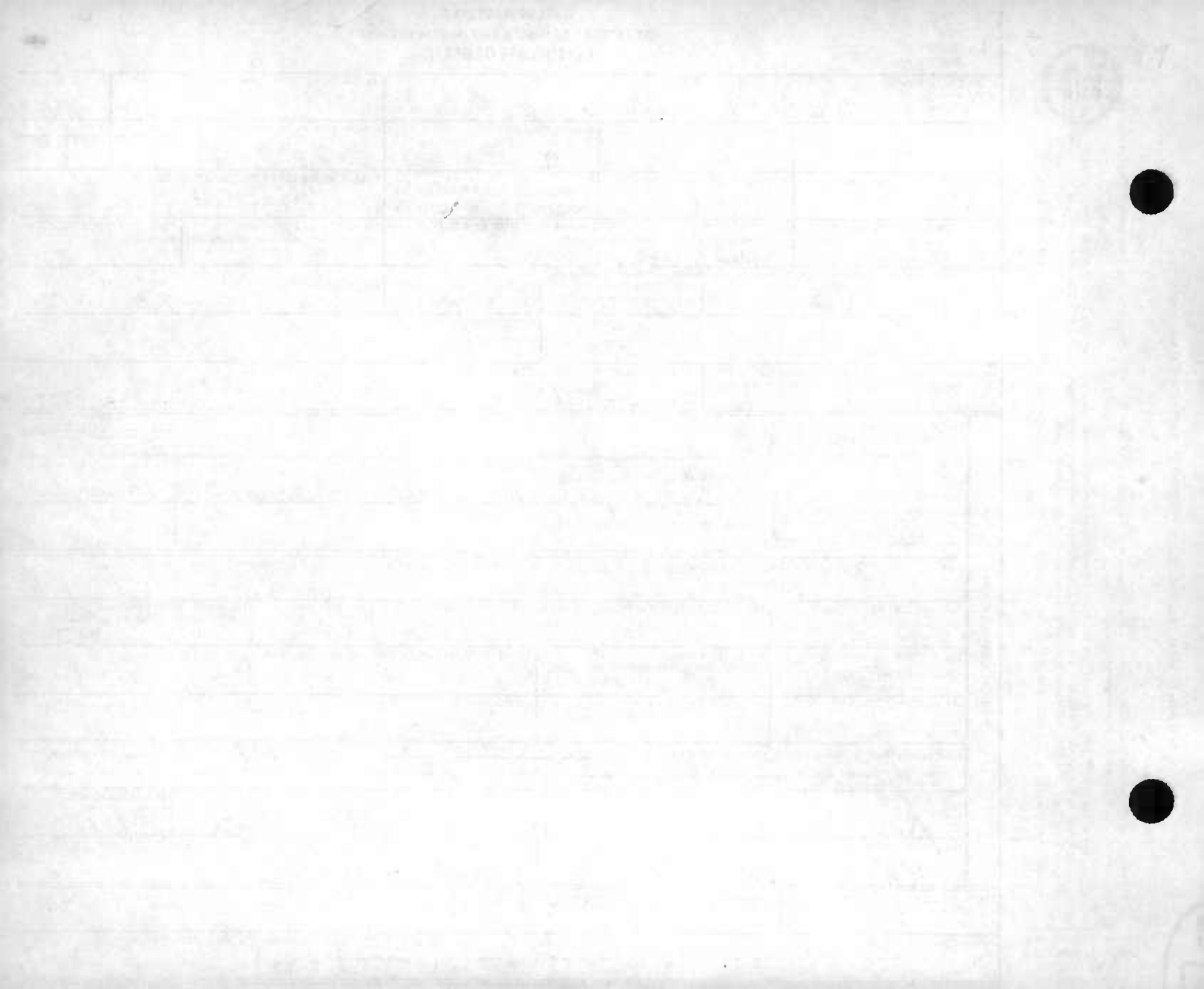
25b. REGISTRAR'S SIGNATURE

John J. Linnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
THELMA V. QUASKY			12 / 16 / 83		12:41 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	March 6, 1910	73 YRS.		BALTIMORE CITY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland	U.S.A.		BALTIMORE CITY		BALTIMORE CITY	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
THE UNION MEMORIAL HOSPITAL		Housewife				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS
13a. STATE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3019 Elm Avenue 21211
13a. COUNTY			13b. CITY OR TOWN			
Maryland			Baltimore			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
John Edward Fitch			Dessi Riley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS
No			213 03 8729 D			22170 Rt. 2 Box 195A Sterling, Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>myocardial infarction - acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>peripheral vascular disease, adult-onset diabetes mellitus, peptic ulcer disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>December 10</u> , 19 <u>83</u> , to <u>December 16</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>December 16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Victoria A. Vanik</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTORIA A. VANIK		22e. ADDRESS 201 EAST UNIVERSITY PARKWAY				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		12-19-83		Lorraine Park Cem		Woodlawn, Balto Co, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Burgee Funeral Home, Baltimore, Maryland		DEC 20 1983		<u>John J. Vanik</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information about death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2008 COLLEGE
UNIVERSITY



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Ethel M. QUINN			2a. DATE OF DEATH MONTH DAY YEAR 12-23-83			2b. HOUR 4:06 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-28-07		6. AGE (In Years Last Birthday) 76		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY STATE Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) University of Maryland Hospital				12. OCCUPATION Housewife			
13a. STATE Md.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS - ZIP CODE 1655 Langford Rd - 21207			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Stull		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Mather		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR PARTIAL) (If YES, Give War or Dates) No					
17a. SOCIAL SECURITY NO. 220-02-2562A		17. INFORMANT William T. Quinn-1655 Langford Rd.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Aortic Stenosis**

4241

DUE TO, OR AS A CONSEQUENCE OF

(b) **Bruscipid Aortic Valve**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 12/23/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/22 , 19 83 , to 12/23 , 19 83 , that (I) (we) last saw the deceased alive on 12/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JAMES GANEY		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (Type or Print) JAMES GANEY		22e. ADDRESS University of Md. Hospital					

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P.A. ADDRESS 736 Edmondson Ave.; Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, no medical examiner's signature is required.

Handwritten notes and scribbles at the top of the page, including the word "Table" and some illegible characters.

Main body of handwritten notes and scribbles, including the word "Baltimore" and various illegible characters.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rose Quirmbach			2a. DATE OF DEATH MONTH DAY YEAR 12 25 83			2b. HOUR 11:20 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 11 90		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME		13a. STATE Md.					
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3305 W. Rogers Ave. #21215	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC BAUMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-01-1388		17. INFORMANT MR. BEN QUIRMBACH			
				ADDRESS 123 WALDRON AVE. #21208 Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>organic brain disease</i>		
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <i>June 10</i> , 19 <i>82</i> , to <i>DEC 25</i> , 19 <i>83</i> , that (I) (we) lost the deceased alive on <i>DEC 25</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <i>Manuel Levin</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D.				22e. ADDRESS 6101 PARK HILLS AVE BALTO. MD 21215			

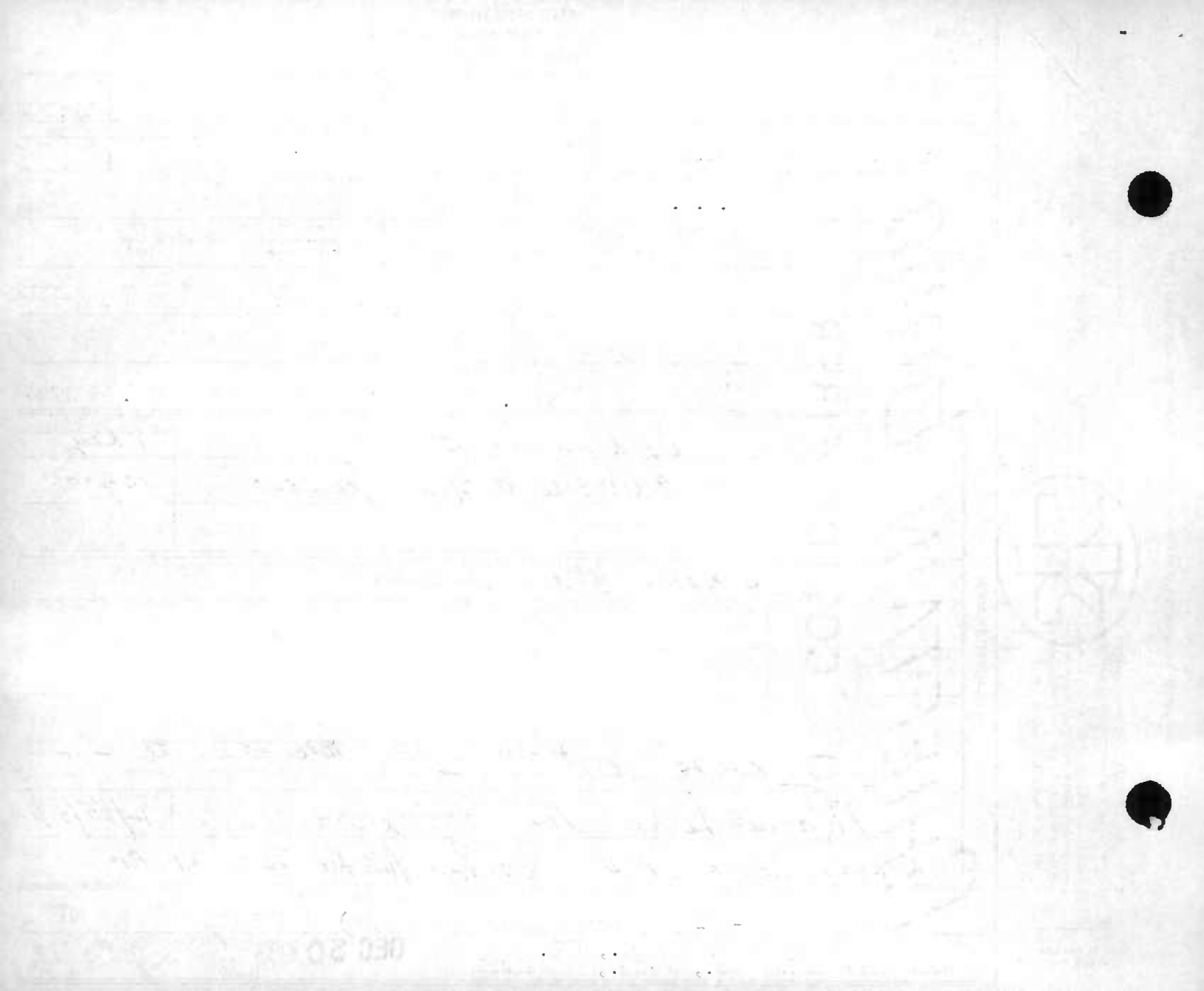
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-26-83		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
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24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE OF DEATH DEC 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



Revised by Dr. Dixon - ME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 3 2 8 4 0	
1. FOR STATE REGISTRAR GOTTFRIED CARL QUOSS SR.				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <i>Gottfried Carl Quoss</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12-23-83</i>	
2b. HOUR <i>6:30 A.M.</i>		3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR <i>AUGUST 18, 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
11. CITY OR TOWN OF DEATH BALTIMORE		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John L. Deaton Medical Center</i>		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5908 OAKLAND ROAD BALTO. 21227		14. FATHER'S NAME FIRST MIDDLE LAST GOTTFRIED C. QUOSS	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA SOHN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-3021	
17. INFORMANT ADDRESS GOTTFRIED C. QUOSS JR. 5908 OAKLAND RD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4140 Acute Episode Probably Cardiac</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASAD</i>		years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>J. A. Gladu, M.D.</i>	
22c. DATE SIGNED <i>12/24/83</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR (NAME) LEROY W. & RUSSELL C. WITZKE FUNERAL HOMES		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	
25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		1630 EDMONDSON AVENUE BALTIMORE MD. 21228			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is not proof of death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) JEANETTE RAFFA					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1983		2b. HOUR 9:45A_M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto...		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 248 S. Castle St 21231					
14. FATHER'S NAME FIRST MIDDLE LAST Frank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Sobatowicz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-07-0288		17. INFORMANT ADDRESS Carol Raffa 1214 N. Charles St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE [Signature]				DEGREE [Signature] ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-9-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TARGOT JEOOY, M				22e. ADDRESS 549 W. Fulton Ave, Ball Md, 21293									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-83		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc. ADDRESS 401 S. Chester St.						25a. DATE REC'D. BY REGISTRAR DEC 14 1983		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

11 21 11 11 0

11 21 11 11 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
HELEN T. RAHLEY		12 17 83	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	Caucasian	12 17 05	78 yrs.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U-S A.		Baltimore City, MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Good Samaritan Hospital	Housewife	Home
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS
Maryland	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1632 Loch Ness Road 21204
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.	
Charles Thompson	Blanche Russell	215-22-0457	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	17b. INFORMANT	17c. ADDRESS	
No	Betty B. Schloerl	21204 1632 Loch Ness Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4100 IMMEDIATE CAUSE (a) Septic Shock.			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
2 MYOCARDIAL INFARCTION.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	HOUR A.M. MONTH DAY YEAR		
	P.M. 19		
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-16-1983, to 12-17-1983, that (I) (we) lost saw the deceased alive on 12-16-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22c. DATE SIGNED
22b. SIGNATURE			12-17-83
Joseph B Reddy			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS
JOSEPH B. REDDY			5601 Loch Raven Blvd, Baltimore, 21239, MD.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	Dec. 19, '83	Moreland Mem. Park	Baltimore Co., MD
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR
NAME ADDRESS			25b. REGISTRAR'S SIGNATURE
William E. Johnson 8521 Loch Raven Blvd.			DEC 19 1983 John J. Conner

BP

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100% COTTON
CIVILIAN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Clementine B Ramsey</i>		MONTH DAY YEAR <i>12-26-83</i>		11 ⁰⁰ AM	
3. SEX <i>FEMALE</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 23 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Federal Hill Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Pvt. Family</i>
13a. STATE <i>Md.</i>		13b. COUNTY <i>Calvert</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Briggs</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Webb</i>		17. INFORMANT ADDRESS <i>2017 Division St. Baltimore, Md. 21217</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-30-0049 A</i>		17. INFORMANT James A. Green	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimer.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/27/83</i> , 19____, to <i>12/26/83</i> , 19____, that (I) (we) saw the deceased alive on <i>12/26/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. J. Folkmann</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/29/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Folkman</i>		22e. ADDRESS <i>Fed Hill Nursing Home</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>01/03/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem. Baltimore</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Nutter & Sons</i>		25a. DATE RECEIVED BY REGISTRAR <i>DEC 30 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	
24. FUNERAL HOME INC. ADDRESS <i>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</i>					

BP _____

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

Domestic Workers, Inc.

217 Division St.

San Francisco, Cal. 94102

Domestic Workers, Inc.

217 Division St.

San Francisco, Cal. 94102

Domestic Workers, Inc.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
KENNETH RAMSEY			12 1 83			6:10p _M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
m	W	2/20/21	62 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MISSOURI	USA		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	VAMC BALTIMORE, MARYLAND 21218			COUNT				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
MD		BALTO.	MIDDLE RIVER	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21220 13200 EASTERN AVE.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
WINDFIELD RAMSEY			BERTHA HASTINGS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
YES			WW II 493 16 3126			PATAICIA KITZMILLER ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1541 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest								5 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) Hepatorenal Syndrome								5 days
(c) Metastatic Adenocarcinoma of Rectum								?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
Cirrhosis, Cachexia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		Colonic Obstruction			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from NOVEMBER 8, 19 83, to DECEMBER 1, 19 83, that (X) (we) last saw the deceased alive on DECEMBER 1, 19 83, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.								
22b. SIGNATURE		DEGREE					22c. DATE SIGNED	
Roger E. Schneider		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					12-2-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Roger E. Schneider		Lodi Raven VA Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
CREMATION		12/5/83		SECURITY PROCESS		BALTO. MD		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.G. CONNELLY		300 MACE		DEC 6 1983		John J. Connelly		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/interment. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilma Ann Raubaugh					2a. DATE OF DEATH MONTH DAY YEAR 12 4 83			2b. HOUR 6:28 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 8 1934		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5404 Cedonia Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leroy C. Smeltzer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline Adams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-28-5801		17. INFORMANT Donald J. Raubaugh		ADDRESS 5404 Cedonia Avenue Baltimore, MD 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: No Lymphoma										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Oct 12/2, 19 83, to Nov Dec 19 83, that (I) (we) lost saw the deceased alive on 12/2, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.										
22b. SIGNATURE Kendall R. Faulkner MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/5/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Faulkner, M.D.					22e. ADDRESS St Joseph's Hospital / Towson md 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/1983		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222					25a. DATE REC'D. BY REGISTRAR DEC 8 1983					
					25b. REGISTRAR'S SIGNATURE John J. Schuch					

BP

9-10-1-1-1

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

[illegible text follows]

[illegible text follows]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
NATHANIEL					RAY	III			12-29-83			M	
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Male	Black	11 17 69	17 YRS.			12-29-83						4:35P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.						Baltimore City MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			Johns Hopkins Hospital										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Maryland						Baltimore			YES			21213 2304 E. Hoffman Street	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Nathaniel			Ray, Jr.			Yvonne			Hood				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
NO						Yvonne Ray 2304 E. Hoffman Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of posterior chest 9651 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
3:20PM 12-29-83			subject shot										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION CITY OR TOWN							
street			1400 blk. Milton Avenue			Baltimore, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12-30-83				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS										
Margarita A. Korell, M.D.			111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY	STATE
BURIAL			1/4/84			Mount Auburn Cem.			Baltimore,				Md.
24. FUNERAL DIRECTOR Name						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Wm March F/H Inc.						1101 E North Avenue			JAN 3 1984 John J. Conner				



LIBRARY



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) ABRAHAM RAYMAN						2a. DATE OF DEATH MONTH DAY YEAR 12-16-83		2b. HOUR 11:00 PM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 15 94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD				
10. CITY OR TOWN OF DEATH BALT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAPER HANGER		12b. KIND OF BUSINESS OR INDUSTRY DECORATIVE		
13a. STATE MD			13b. COUNTY MD		13c. CITY OR TOWN BALT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST MORDECAI RAYMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHARNA UNKNOWN			13e. ADDRESS 2500 W. BELVEDERE AVE., APT 719				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-09-3066		17. INFORMANT MR. JACK RAYMAN				ADDRESS 612 KAHN DR. #21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC BLADDER CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR TERMINAL GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12-10-83 , to 12-16-83 , that (I) (we) last saw the deceased alive on 12-16-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-16-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES SCHWARTZ, MD				22e. ADDRESS SINAI HOSP. BALT. MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-18-83		23c. NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL ANSHE SEARD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD				
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 20 1983				
25b. REGISTRAR'S SIGNATURE [Signature]										



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MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
EDWARD L. REBSTOCK				December 29, 1983				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		October 29, 1910		73		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Good Samaritan Hospital				Sheetmetal Construction					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Frank Rebstock				Sarah Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				WWII		215-09-8827 Mrs. Mildred E. Rebstock, same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>70</u> to <u>DEC</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>APRIL 20</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M. M. Menendez, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/30/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Marcio M. Menendez, M.D.				5820 York Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1-3-84		Savannah Cemetery		Savannah, Missouri					
24. FUNERAL DIRECTOR NAME				1050 York Rd. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ruck Towson Funeral Home, Inc.				Towson, Md. 21204		JAN 3 1984		<u>John J. Casper</u>			

December 22, 1953

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
CHARLES HOWARD REED			12 4 83			2:07P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	Nov. 17, 1928	55			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	USA		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	VETERANS ADMINISTRATION MEDICAL CENTER			Truck Driver			Delivery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland	Harford	Edgewood	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1702 Emmorton Road 21040		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
William Justin Reed			Alice Blanche Altizer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes			Korea			Md. 21040		
			224 32 4360			Betty Jean Reed, 1702 Emmorton Rd, Edgewood		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

5326 IMMEDIATE CAUSE (a) CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 minutes

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

INTRABDOMINAL HEMORRHAGE

on day

DUE TO, OR AS A CONSEQUENCE OF

GASTRIC LEAKAGE

3-5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

METASTATIC LUNG CANCER

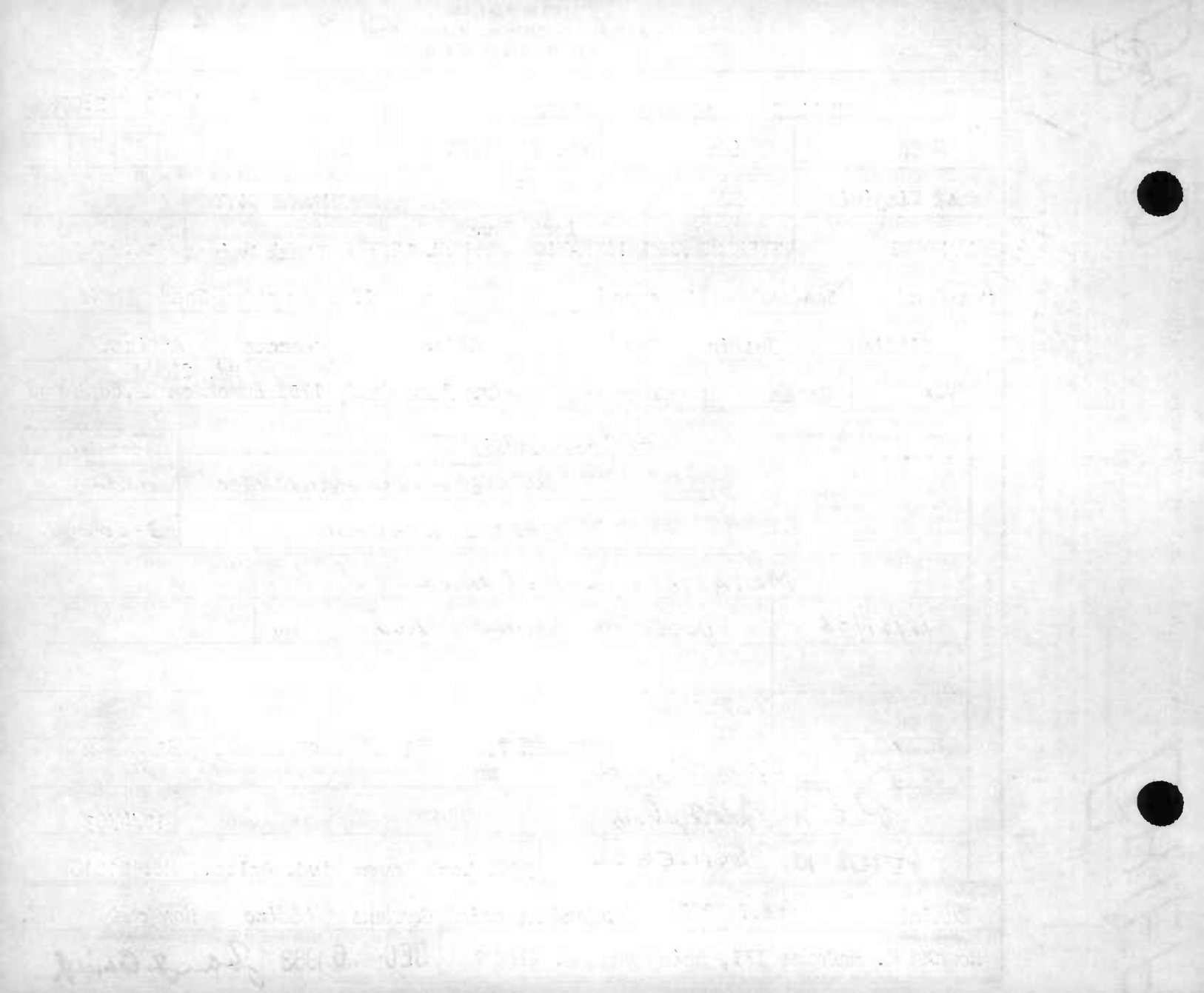
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11/21/83		DUODENUM PERFORATION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 7, 1983, to DECEMBER 4, 1983, that X (we) lost saw the deceased alive on DECEMBER 4, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Peter N. Schlegel MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
PETER N. SCHLEGEL				3900 Loch Raven Blvd. Balto., Md. 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Dec. 7, 1983	Harford Memorial Gardens	Aldino Harford Md.
24. FUNERAL FURNISHER		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Howard K. McComas III, Abingdon, Md. 21009		DEC 6 1983 John J. Casier	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner must be notified at once.



Items 18-22a 3/12/84 mtb F#589

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

3 2 8 5 0

1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Patricia L. Reed			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 31 19 83			2b. HOUR M				
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4-2-1963	6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 31 19 83			2d. HOUR M 4:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Alrick Way (woods)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME.		
13a. STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21205 1026 QUANTRIL WAY
14. FATHER'S NAME FIRST MIDDLE LAST JAMES W. REED				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRENDA J. HITCHCOCK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS James W. Reed - 1026 Quantril Way 21205					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries 8920 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12/31 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject came into contact with bonfire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Woods		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Alrick way, Baltimore, Md.					
22a. I certify that I took charge of the body described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief					DATE SIGNED 1/1/84		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-5-84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILLS Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME Gentry Hill - 2334 Jefferson St.					ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

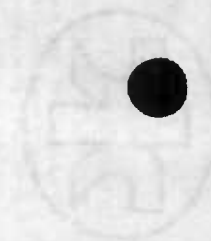
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
WALTER A		REEG		12 6		83 12:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR		71		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		GOOD SAMARITAN		CARPENTER		CONTRACTOR	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE		LARNY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
HARRY		REED		YES		216-05-9668	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic oat cell Ca of lung 1629		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
FAMILY RECORDS		Gambrell				One wk	
19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		COPD		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/29/83, 19, to 12/6/83, 19, that (I) (we) last saw the deceased alive on 12/6/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
JYOTIN PARIKH		Intern.				12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
JYOTIN PARIKH		Good Samaritan Hospital		BURIAL		DEC 9, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
PARKWOOD CEM.		PARKVILLE BALTA MARYLAND		EVANS CHAPEL OF MEMORIES HARFORD ROAD		DEC 8 1983	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE					
John J. Lauer							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



TO: MR. J. H. HARRIS, JR.
FROM: MR. J. H. HARRIS, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)					MONTH DAY YEAR					MONTHS DAYS HOURS MIN.
FIRST MIDDLE LAST					12 13 83					7:50 P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male		White		MONTH DAY YEAR		72 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		North Charles General Hosp.		Inventory Clerk		Beth. Steel				
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST		FIRST MIDDLE LAST								
Harry G. Reel		Sadie Coleman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		AD 7704 Charlesmont Rd. Balto., MD. 21222				
No		189-01-2502		Bette Uphoff						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										<u>3 days</u>
4100										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>										<u>9 yrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
<u>Congestive Heart Failure, Pneumonia, Diabetes mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>83</u> , to <u>12/13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Veneranda G. Barnes</u> M.D.						DEGREE		22c. DATE SIGNED		
						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
Veneranda G. BARNES						NORTH CHARLES GEN. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			12/16/83		Moreland Memorial		Baltimore		Maryland	
24. FUNERAL DIRECTOR Duda-Ruck, Inc.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
7922 Wise Avenue Dundalk, MD. 21222						DEC 16 1983		<u>John J. Connel</u>		

BP

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[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>WILLIE REESE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 12 83</i>			2b. HOUR <i>9 39</i> M			
3. SEX <i>FEMALE</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 9 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTIMORE CITY</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PROVIDENT HOSPITAL BALTIMORE</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1102 Druid Hill Ave. Apt. 307 Balto. Md. 21201</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ben Coglin</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sallie Ellison</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>214 74 0988</i>		17. INFORMANT <i>Dorothy M. Johnson</i>		ADDRESS <i>2622 Forest Park Ave. Balto. Md. 21216</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-12</i> , 19 <i>83</i> , to <i>12-12</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12-12</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sher Afzal Hashmi MD</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12-12-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SHER AFZAL HASHMI</i>					22e. ADDRESS <i>2600 LIBERTY HEIGHTS AVE</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/17/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Anne Arundel Co. Md.</i>		
24. FUNERAL DIRECTOR NUTTER & SONS 2501 Gwynns Falls NAME ADDRESS <i>FUNERAL HOME INC. Pkwy. Baltimore, Md. 21216</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 15 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Gaird</i>		

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly completed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S.A.

1105 CUNYAN BLVD
 NEW YORK, N.Y. 10021

1105 CUNYAN BLVD
 NEW YORK, N.Y. 10021

1105 CUNYAN BLVD
 NEW YORK, N.Y. 10021

1105 CUNYAN BLVD
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1105 CUNYAN BLVD
 NEW YORK, N.Y. 10021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical certificate must be filled in.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM REHBERGER, JR.				2a. DATE OF DEATH MONTH DAY YEAR 12/4/83				2b. HOUR 9.25 PM			
3. SEX M.		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 30 02		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES MANAGER		12b. KIND OF BUSINESS OR INDUSTRY REVERE COPPER & BRASS			
13a. STATE MARYLAND		13b. COUNTY —		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21234 2717 INGLEWOOD AVE.			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM REHBERGER, JR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE SCHAEFLING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-10-0315		17. INFORMANT MRS. ELENORA GREEN				ADDRESS 21207 3335 COURTLIGH DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA & Extension to Brain Stem. 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH since 11/30/83	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 83 , to 12/4 , 19 83 , that (I) (we) last saw the deceased alive on 12/4 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE				22c. DATE SIGNED 12/4/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HUIE.				22e. ADDRESS GOOD SAMARITAN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-8-83		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24. FUNERAL DIRECTOR NAME ADDRESS HARTLEY MILLER 1521 HARFORD RD.				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE [Signature]					

18

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MABLE MARIE REIGLE			2a. DATE OF DEATH MONTH DAY YEAR December 8, 1983			2b. HOUR 11:40a			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Baltimore General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Harmans		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William S. Horsey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary P. Dowling			13e. STREET ADDRESS (21077) 7541 Old Coaling Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (son) Mr. James C. Peleska		ADDRESS 7520 Old Coaling Road, Baltimore, Md. 21077		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ishemic ASCVD</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4148	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>12/8/83</u> to <u>12/8/83</u> , that (we) lost <u>12/8/83</u> above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald R. Black, M.D.</u>						DEGREE M.D.		22c. DATE SIGNED <u>12/8/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DONALD R. BLACK, M.D.</u>						22e. ADDRESS <u>S.B.S.H.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE December 12, 1983			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A., MD.	
24. FUNERAL DIRECTOR NAME <u>H. M. Hopkins</u>						ADDRESS Singleton Funeral Home Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR DEC 13 1983	
						25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

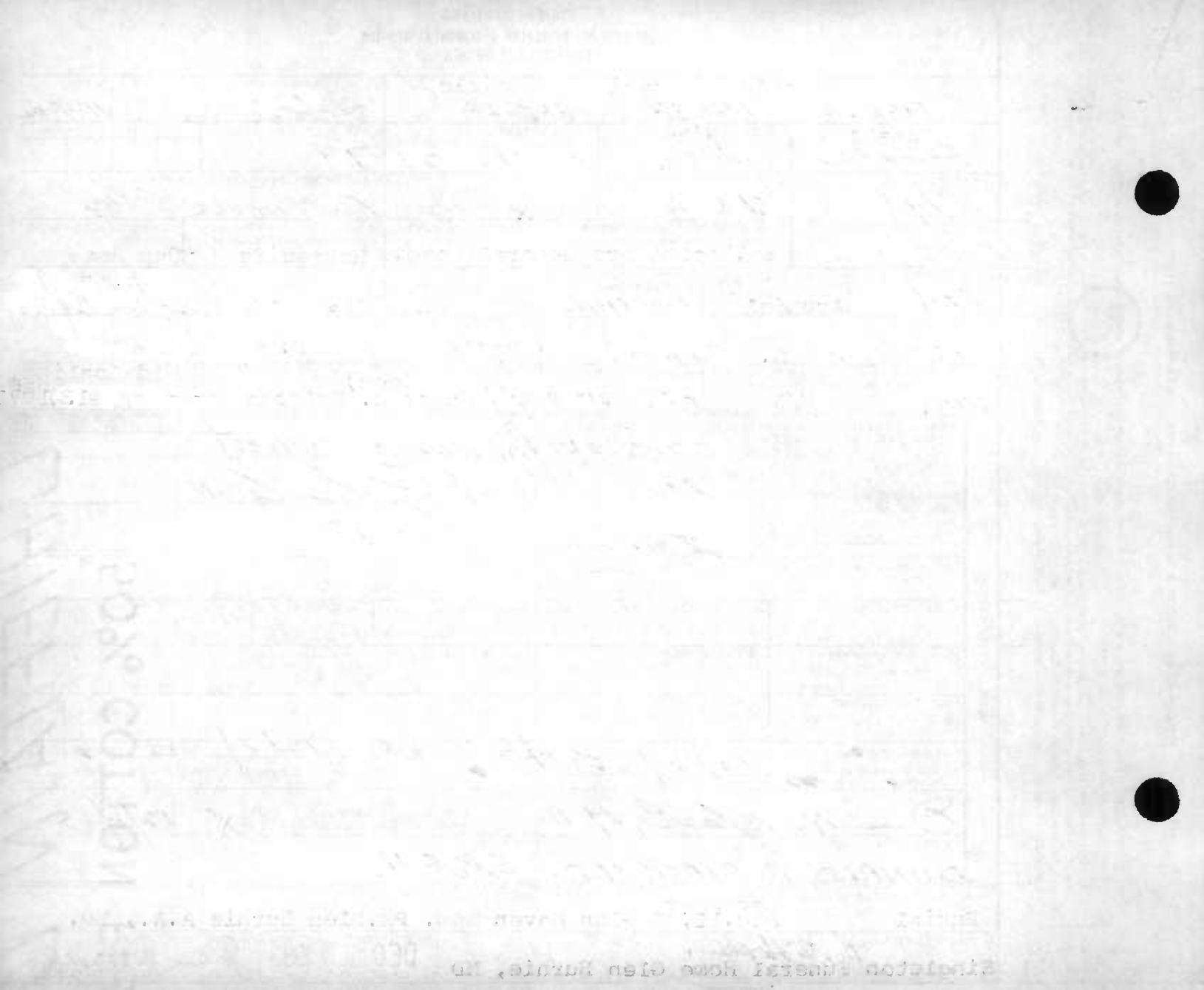
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified and a medical investigation must be conducted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard E. Rein				2a. DATE OF DEATH MONTH DAY YEAR December 30, 1983			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4300 N. Charles Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Equitable Trust Bank		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Frederick Rein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-6177		17. INFORMANT ADDRESS Helen B. Rein, Same As #13e 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas & metastases</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since June 83</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>7-11</u> 19 <u>62</u> , to <u>12-30</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A.G. Ossman M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.G. Ossman M.D.				22e. ADDRESS 1101 St. Paul Street, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL <u>Entombment</u>		23b. DATE 1-3-84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 204 4 1984 <u>John J. Canine</u>			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT F. REISFELD			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1983		2b. HOUR 8 A M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5804 GREENSPRING AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER	12b. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL PROCESSING INSTITUTE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM REISFELD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA F. FEIKIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-NAVY 213-34-7146		17. INFORMANT ADDRESS MRS. MARIAN REISFELD 5804 GREENSPRING AVE. BALTO., MD 21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12/15 , 19 83 , to 12/30 , 19 83 , that (I) (the hospital) saw the deceased alive on 12/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE James Reisfeld M.D. KLEEMAN				22c. DATE SIGNED 12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES REISFELD M.D.				22e. ADDRESS 7600 OSLER DR.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 1, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	
23d. LOCATION BALTIMORE		COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 5 1984	
				25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.	
LILLIAN V. REISS					12	24	83		7	50 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	White	10-4-95		88		MONTHS		DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.	U.S.A.			BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE	UNION MEMORIAL HOSPITAL			Housewife							
13a. STATE				13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Md.					Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4503 Woodlea Ave. 21206		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
George Stetter				Anna Keimig							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				216-03-0836 D		Delores Reiss, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Coronary Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Mitral Regurgitation / Aortic Stenosis / ? Gram negative cocci blood</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I, this hospital) attended the deceased from <u>12/23</u> , 19 <u>83</u> , to <u>12/24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.				22b. SIGNATURE <u>Robert A. Miller</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12/24/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ROBERT A. MILLER M.D.				UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial				12-28-83		Holy Redeemer			Balto. MD		
24. FUNERAL DIRECTOR NAME				25. DATE RECEIVED BY REGISTRAR				26. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc., 5305 Harford Rd.				DEC 27 1983				<u>John J. Calver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Burial/transit should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be certified by a coroner.

1122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR J. RENZI, SR.			2a. DATE OF DEATH MONTH DAY YEAR 12/31/83		2b. HOUR 2:01 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV 23 1918		6. AGE (IN YEARS (LAST BIRTHDAY)) 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shaw Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Technician		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAVERIO RENZI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUISA B. CASSERTA		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215-12-5067	
17. INFORMANT NAME AMELIA B. RENZI		17. ADDRESS 5506 REMMELL AVE 21206		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4860 DUE TO, OR AS A CONSEQUENCE OF: (b) Septicemia DUE TO, OR AS A CONSEQUENCE OF ASPIRATION PNEUMONIA (c) Aspiration pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 83 , to 12/31 , 19 83 , that (I) (we) lost saw the deceased alive on 12/31 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Deborah L. Bernal M.D.				22c. DATE SIGNED 12/31/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEBORAH L. BERNAL	
22e. ADDRESS 1421 COLUMBIA RD NW #401				22f. DATE REC'D. BY REGISTRAR JAN 3 1984			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gch		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Md	
24. FUNERAL DIRECTOR NAME HARTLEY Miller Funeral Homes				24. ADDRESS 7527 Harford Rd		25a. DATE REC'D. BY REGISTRAR JAN 3 1984	
25b. REGISTRAR'S SIGNATURE John J. Conner				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LEVI, VICTOR
796123 S307D HED S
12/23/83 MAY LEVIN
PLESANT MAJOR
21215 M 11/18044004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) EMMA H RHENEY					2a. DATE OF DEATH MONTH DAY YEAR 12 03 83			2b. HOUR 1:15 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 407 Hawthorne Rd. 21210	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Hammell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nolan Russell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 258-03-0737		17. INFORMANT Martha C. Rheney ADDRESS 7 Nightingale Way Lutherville, Md. 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCUD 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/19 , 19 83 , to 12/3 , 19 83 , that (I) (we) lost saw the deceased alive on 12/3 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Brian H. Kahn, MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN H. KAHN, M.D.					22e. ADDRESS 201 E UNIVERSITY PKWY				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Transit			23b. DATE Dec. 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Magnolia		23d. LOCATION CITY OR TOWN COUNTY STATE Augusta, Richmond Co. Georgia		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212					25. DATE RECEIVED BY REGISTRAR DEC 07 1983				

NAME: [illegible] ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DATE: [illegible] TIME: [illegible] FROM: [illegible] TO: [illegible]

REASON: [illegible] COMMENTS: [illegible]

SIGNATURE: [illegible] TITLE: [illegible]

ORGANIZATION: [illegible] CONTACT: [illegible]

REFERENCE: [illegible] NOTES: [illegible]

DATE: [illegible] TIME: [illegible] FROM: [illegible] TO: [illegible]

REASON: [illegible] COMMENTS: [illegible]

SIGNATURE: [illegible] TITLE: [illegible]

ORGANIZATION: [illegible] CONTACT: [illegible]

REFERENCE: [illegible] NOTES: [illegible]

DATE: [illegible] TIME: [illegible] FROM: [illegible] TO: [illegible]

REASON: [illegible] COMMENTS: [illegible]

SIGNATURE: [illegible] TITLE: [illegible]

ORGANIZATION: [illegible] CONTACT: [illegible]

REFERENCE: [illegible] NOTES: [illegible]

DATE: [illegible] TIME: [illegible] FROM: [illegible] TO: [illegible]

REASON: [illegible] COMMENTS: [illegible]

SIGNATURE: [illegible] TITLE: [illegible]

ORGANIZATION: [illegible] CONTACT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT E. RHODES			2a. DATE OF DEATH MONTH DAY YEAR 12/5/83			2b. HOUR 7A M				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6/12/14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY retiree		
13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 301 WEST FRANKLIN ST 21201	
14. FATHER'S NAME FIRST LAST William T. Rhoads				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Vickers				ADDRESS BALTO., MD. 21226		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-12-3574		17. INFORMANT Florence Hohman		ADDRESS 7108 Ft. Smallwood Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) None										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/18/83, 1983, to 12/5/83, 1983, that (I) (we) lost saw the deceased alive on 12/4/83, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Mark Davis					DEGREE MD		22c. DATE SIGNED 12/5/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK DAVIS M.D.					22e. ADDRESS 9051 BALTIMORE AVE E.C. 21843					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/5/83		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR McCully Funeral Home					25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Smith			



William T. Thomas, Jr.
Lawrence Morris 7107 E. Washington St.
Chicago, Ill. 60628

Continuation
of a letter to the
Security Council
dated 12/7/53

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE W. RIDGELY			2a. DATE OF DEATH 12-28-83			2b. HOUR 6:30PM		
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-14-15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Welder		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1700 Lenore Court Woodlawn 21207
14. FATHER'S NAME FIRST MIDDLE LAST Charles Ridgely			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie J. J. J.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 215-07-5319		17. INFORMANT ADDRESS Donald G. Ridgely 2838 Rogers Ave 21043 Ellicott City			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral lung carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 13 83 Dec 28 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2000 W. Baltimore Street Carroll Maryland			
22a. I certify that (I) (this hospital) attended the deceased from Dec 28 1983 to Dec 28 1983 , that (I) (we) lost saw the deceased alive on Dec 28 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. Taldondo			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. TALDONDO			22e. ADDRESS 2000 W. Baltimore Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 31, 1983		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Maryland	
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City					25a. DATE REC'D. BY REGISTRAR DEC 30 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

1948-1949

1700 Lenore Court Woodbury
Weider

Donald C. Kinkaid 1838 Rogers Ave 11053

Harry H. Wierke 4112 Columbia Ellipse City
Carol H. Wierke 4112 Columbia Ellipse City
Dec 31, 1949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Joseph Creighton Riepe				2a. DATE OF DEATH: MONTH Dec DAY 1 YEAR 83 2b. HOUR 12¹⁰ PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April DAY 17 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) Keswick Nursing Home.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Invest. Bank.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Harry MIDDLE U. LAST Riepe				15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST North			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-0589		17. INFORMANT ADDRESS George M. S. Riepe Monkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 103 hrs 4 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CVA and Right Hemiplegia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 28 Jul 19 82 , to 1 Dec 19 83 , that (I) (we) last saw the deceased alive on 1 Dec 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Aubrey D. Richardson M.D.				DEGREE M.D.		22c. DATE SIGNED 1 Dec 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aubrey D. Richardson M.D.				22e. ADDRESS 700 W. 40th St., Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-3-83		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN Pikesville COUNTY Balto STATE Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co., Balto., Md.				25a. DATE REC'D. BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE John J. Carney	

Henry W. Jenkins & Sons Co., Baltimore, Md. DEC 2 1893

Export 11-12 1/2 Lb. Price \$1.00 Baltimore, Md.

Superior D. Flour 100 lb. \$1.00 Baltimore, Md.



RECEIVED
NOV 10 1893

212 03-0338, George M. S. Bisco, Montreal, V.

Henry W. Jenkins & Sons Co., Baltimore, Md.

Wm. J. Bisco, Baltimore, Md.

Superior D. Flour 100 lb. \$1.00 Baltimore, Md.

U.S.A. Baltimore, Md.

Nov 17 1893

George M. S. Bisco, Montreal, V.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Johnathan Scott Riffe</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>12 14 83</u>		2b. HOUR 12:27 P.M.	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>9 6 83</u>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>0 99</u>	
9. CITY OR TOWN OF DEATH <u>Balt. City</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>NA</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>CARROLL</u>		13c. CITY OR TOWN <u>Sykesville</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Ernest Wayne Riffe</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Tanet L. Dixon</u>		17. INFORMANT ADDRESS <u>Ernest Wayne Riffe, Sykesville</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Ernest Wayne Riffe, Sykesville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>7651</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intractable Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1983</u> to <u>Dec 14, 1983</u> , that (I) (we) last saw the deceased alive on <u>Dec 14, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael A. Stoiko MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/14/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Stoiko</u>		22e. ADDRESS <u>Dept. Pediatrics Univ. of Md Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-16-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leake View Memorial Park</u>	
24. FUNERAL DIRECTOR NAME <u>Harry W. Haight</u>		ADDRESS <u>Sykesville</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1983</u>	
				25b. REGISTRAR'S SIGNATURE <u>John G. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



2002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		4 M	
FIRST MILDRED		12/11/83			
MIDDLE A					
LAST RILEY					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	white	MONTH DAY YEAR	69 YRS	IF UNDER 24 HRS.	
		01 31 14		MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
BAIT	US	9. BALTIMORE CITY OR COUNTY OF DEATH			
		BAIT CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BAIT CITY	John L. DEATON Medical Center	Waitress		Retired	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	BALTA	BAIT FERNDALE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	301 WELHAM AVE	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST HARRY	FIRST KATHLEEN				
MIDDLE	MIDDLE				
LAST NYNN	LAST SOLER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	215-18-3376	Lois Lane, daughter, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					
1541					
DUE TO, OR AS A CONSEQUENCE OF					
(b) RECTAL CANCER WITH METASTASES					22 MONTHS
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC - 7, 19 83, to DEC 11, 19 83, that (I) (we) last saw the deceased alive on DEC - 11, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Charles Rosenfarb, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CHARLES ROSENFARB, MD		J.L. DEATON MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	14 Dec. 83	Meadowridge Mem. Pk.		Elkridge, Howard, Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James S. Kirkley, Glen Burnie, Md.		DEC 12 1983		John J. Carver	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 4 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CHARLES EDWARD RINGER						2a. DATE KNOWN OF DEATH 12-8-83		2b. HOUR 6PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb 19 1957	6. AGE (IN YEARS) 26 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12-8-83		2d. HOUR 6PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY AA		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 4500 Ritchie Highway				13f. ZIP CODE 21225							
14. FATHER'S NAME FIRST George MIDDLE W. LAST Ringer				15. MOTHER'S MAIDEN NAME FIRST Charlsie MIDDLE Stallings LAST Stallings							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-78-2782		17. INFORMANT George W. Ringer, 208 Parkwood Drive, Goldsboro, N.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Smoke and soot inhalation 8902 IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:54PM 12-8-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in house fire							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bed		21f. LOCATION STREET 4500 Ritchie Hgwy. CITY OR TOWN Baltimore, COUNTY Maryland STATE MD							
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 12-9-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10 Dec 83		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN Catonsville COUNTY Balti. STATE MD					
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD ADDRESS				25a. DATE REC'D BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>					

RECEIVED

RECEIVED

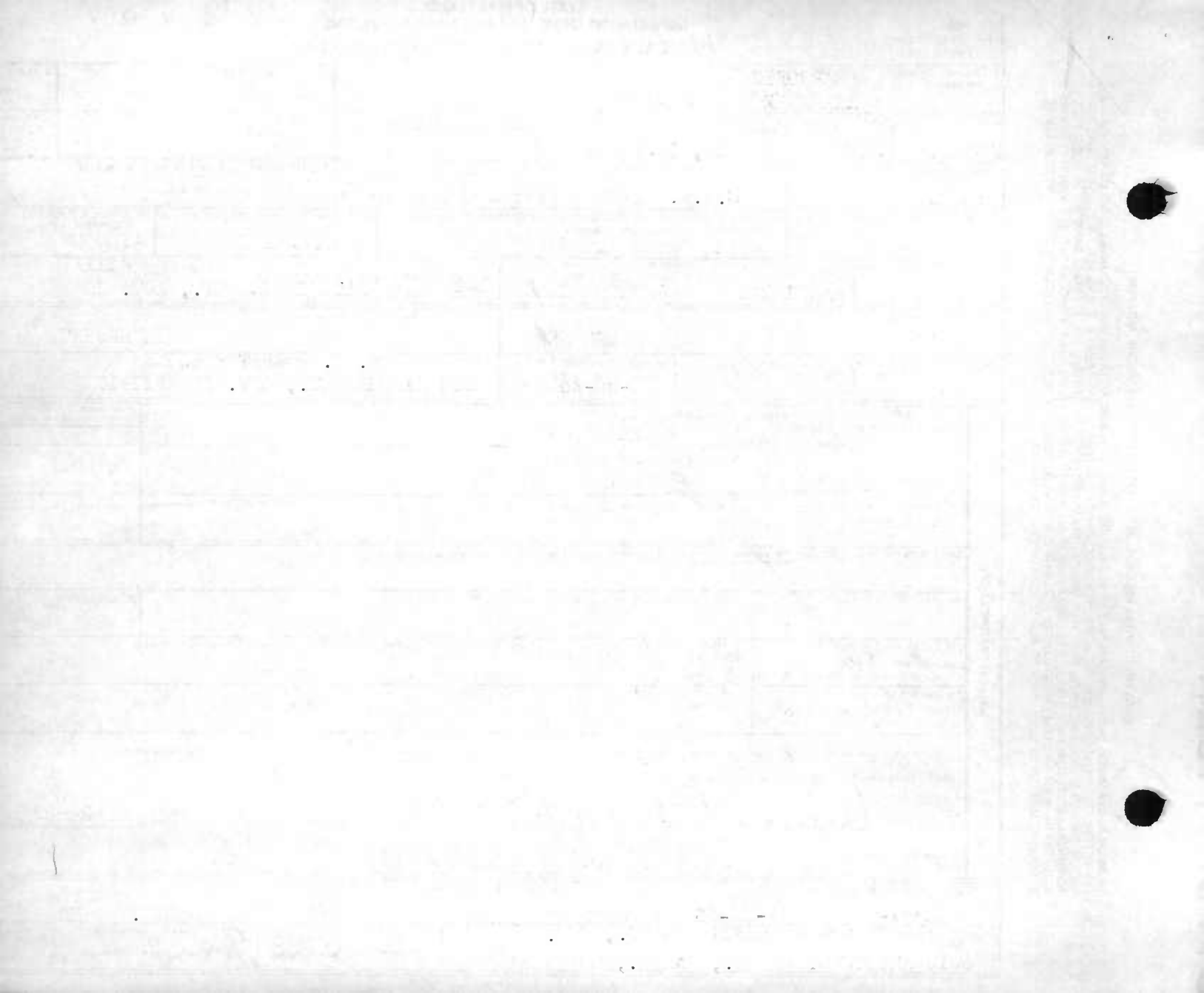
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) MARJORIE MARION Robbins										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-23 1983		2b. HOUR M 11:00 a.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 21, 1927	6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN. Y		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-23 1983		2d. HOUR M 11:00 a.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										#21117		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN OWINGS MILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 210 MIDPINE CT., APT. 2D				
14. FATHER'S NAME FIRST MIDDLE LAST HARRY GOLOMBECK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEAH SILVERBERG								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 220-20-2284		17. INFORMANT MR. I. ROBERT ROBBINS 210 MIDPINE CT., APT. 2D #21117						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9540 IMMEDIATE CAUSE (a) Aspiration Pneumonia Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Drowning DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. ? 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject jumped into water								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ?		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ? ? ? ? ?								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant						DATE SIGNED 12-24-83				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-26-83		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD						
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD J. ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1983			2b. HOUR 5:35AM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1-18-1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY - MD.				
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY STEEL CO.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.					13b. CITY OR TOWN BALTO.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 7754 EASTDALE RD. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ROBERTS.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA WALTERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-05-3145			17. INFORMANT ADDRESS Mrs. Anna C. Roberts - 7754 Eastdale Rd. 21224				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5712 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF HEPATIC COMA (b) DUE TO, OR AS A CONSEQUENCE OF END STAGE CIRRHOSIS OF LIVER (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ALCOHOL ABUSE, XXX ESOPHAGEAL VARICES (HISTORY OF)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital attended the deceased from DEC. 5, 1983 , to DEC. 9, 1983 , that (I) (we) last saw the deceased alive on DEC. 9, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (a) (b) (did not) view the body after death.										
22b. SIGNATURE John Mannisi						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. MANNISI, M.D.						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-13-83		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Faithful - 7527 Harbor Rd.						25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE John J. Conick		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed after 24 hours.

20% COON L

CHIEF AM



BURIAL 15-13-88 PARADISE OF FAITH BAYVIEW, MD

1513 15th St. N.W. - 1513 15th St. N.W.

NO	—	JOHN ROBERTS	ELSA WATERS	31034
MR	BALTO	BALTO	X	2754 EASTDALE RD
BALTO	CHURCH HOSPITAL	OPERATOR	BALTIMORE CITY -	31034
M	U.S.A.	X	1-18-1911	13
W				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eliza Ann Roberts						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 15 83		2b. HOUR 3:16 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 17 1900		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 83		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 15 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 W. 42nd Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elevator Operator		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1000 W. 42 nd. Street Baltimore, Maryland 21211			
14. FATHER'S NAME FIRST MIDDLE LAST John S. Dorsey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Davis				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 215-03-2466				17. INFORMANT James Dorsey				ADDRESS 8260 North East Third Court Miami, Fla. 33138			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12/16/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/20/1983		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS NUTTER & SONS 2501 Gwynns Falls Funeral Home Inc. Pkwy. Balto. Md. 21216						25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE J. J. C. Chief			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BRINTON DENNIS ROBINSON, JR.			2a. DATE OF DEATH MONTH DAY YEAR 12-20-83			2b. HOUR 10 ²⁰ A.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Toppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3301 Clayton Road 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Brinton Daniel Robinson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Evelynna Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YEAR OR DATES) 000000		17. INFORMANT ADDRESS Toppa, Md. 21085 Harvey R. Robinson, 3303 Clayton Road,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>2030</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE MYELOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>LEUKEMIA, ANEMIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 17</u> , 19 <u>83</u> , to <u>Dec 20</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thodore Kramer MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>T. I. KRAMER</u>				22e. ADDRESS <u>UNION MEMORIAL HOSP.</u>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Dec. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Tabernacle U. Methodist Cemetery, Fallston-Harford-Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) CHARITA (CHERITA) R. (WILLIAMS) ROBINSON						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12-9-83		2b. HOUR 1AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 11 DAY 21 YEAR 83		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS 18 YEARS 18		7c. DATE PRONOUNCED DEAD MONTH 12 DAY 9 YEAR 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1116 N. Monroe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1116 N. Monroe St. 21217	
14. FATHER'S NAME FIRST William MIDDLE Robinson LAST Robinson				15. MOTHER'S MAIDEN NAME FIRST Patricia MIDDLE A. LAST Pumphrey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Adelaide Pumphrey 1615 Bakbury Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke and soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:45AM 12-9-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) caught in housefire			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 1116 N. Monroe St. CITY Baltimore STATE Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-9-83	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Anne Arundel Co. COUNTY MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Laniel</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their pleasure is to be ascertained. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. **12/05/83**

IMPORTANT: If item 21 is marked or item 18 shows symptoms of a traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
DOUGLAS ROBINSON			DECEMBER 8 1983			5:35A M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male	Black	12 5 83	YRS. 3					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			937 Duncan Street 21205		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Victor W. Robinson			Gloria Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			N/A			Corine G. Jones 3100 Oakfield Avenue		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest		Immediate	
7468 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		3 days	
(b) Hypoplastic Left Ventricle			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
None							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from December 7, 1983, to December 8, 1983, that (1) (we) lost saw the deceased alive on Dec 8 5:35 AM 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A Wood MD				DEGREE		22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A Wood				22e. ADDRESS Dept Pediatrics Johns Hopkins Hospital			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	12/12/83	Eastview Mem. Pk.	Baltimore, Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Wm C March F/H Inc. 1101 E. North Ave.		DEC 12 1983	
25b. REGISTRAR'S SIGNATURE			
		John J. Connel	

THE FIRST BOARD

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THE FIRST BOARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

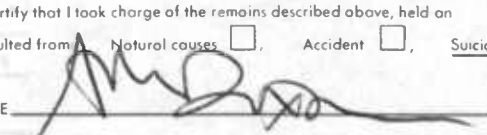

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Samuel NMN Robinson					12 1 1983					11 a.m.			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 8 22 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 N. Woodington Rd. #A9 21229					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Robinson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-09-8420		17. INFORMANT ADDRESS Lucy B. Robinson 12 N. Woodington Rd									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE MYELOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>MARKED RENAL DISEASE</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>27 Nov</u> , 19 <u>83</u> , to <u>1 Dec</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on 1 Dec</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>James E Taylor</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>12/2/83</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES E TAYLOR</u>				22e. ADDRESS <u>ST AGNES HOSPITAL</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 5 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

DEC 8 1986

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 32874
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Paul ROBINSON						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 10 1983		2b. HOUR 2:30		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1964	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 19	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 10 1983		2d. HOUR 2:30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6617 F. English Oak Road 21234		
14. FATHER'S NAME FIRST MIDDLE LAST John M. Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane C. Clair						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 217-54-8960		17. INFORMANT ADDRESS John M. Robinson, 111 1774 Hillmeade Sq. Frederick, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9530 Hanging Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:40 M. 12-6- 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Spring Grove Hosp. Balto. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12-11-83		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-83		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE 				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL C RODEN			2a. DATE OF DEATH MONTH DAY YEAR 12 30 83		2b. HOUR 8:40 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 03 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH STEEL	
12b. KIND OF BUSINESS OR INDUSTRY STEEL						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET NAGEL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-01-6336		17. INFORMANT ADDRESS MARGARET RODEN SAME AS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PONTINE INFARCTION						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 83 , to 12/30 , 19 83 , that (I) (we) lost saw the deceased alive on 12/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Chris Ross MD		22c. DATE SIGNED 12/30/83			22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRIS ROSS	
22e. ADDRESS BALTO CITY HOSP.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/2/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.
24. FUNERAL DIRECTOR NAME ADDRESS CONNELLY FUNERAL HOME OF DUNDALK		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE <i>George C. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at _____

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Item 13e per ph.
12/29/83FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

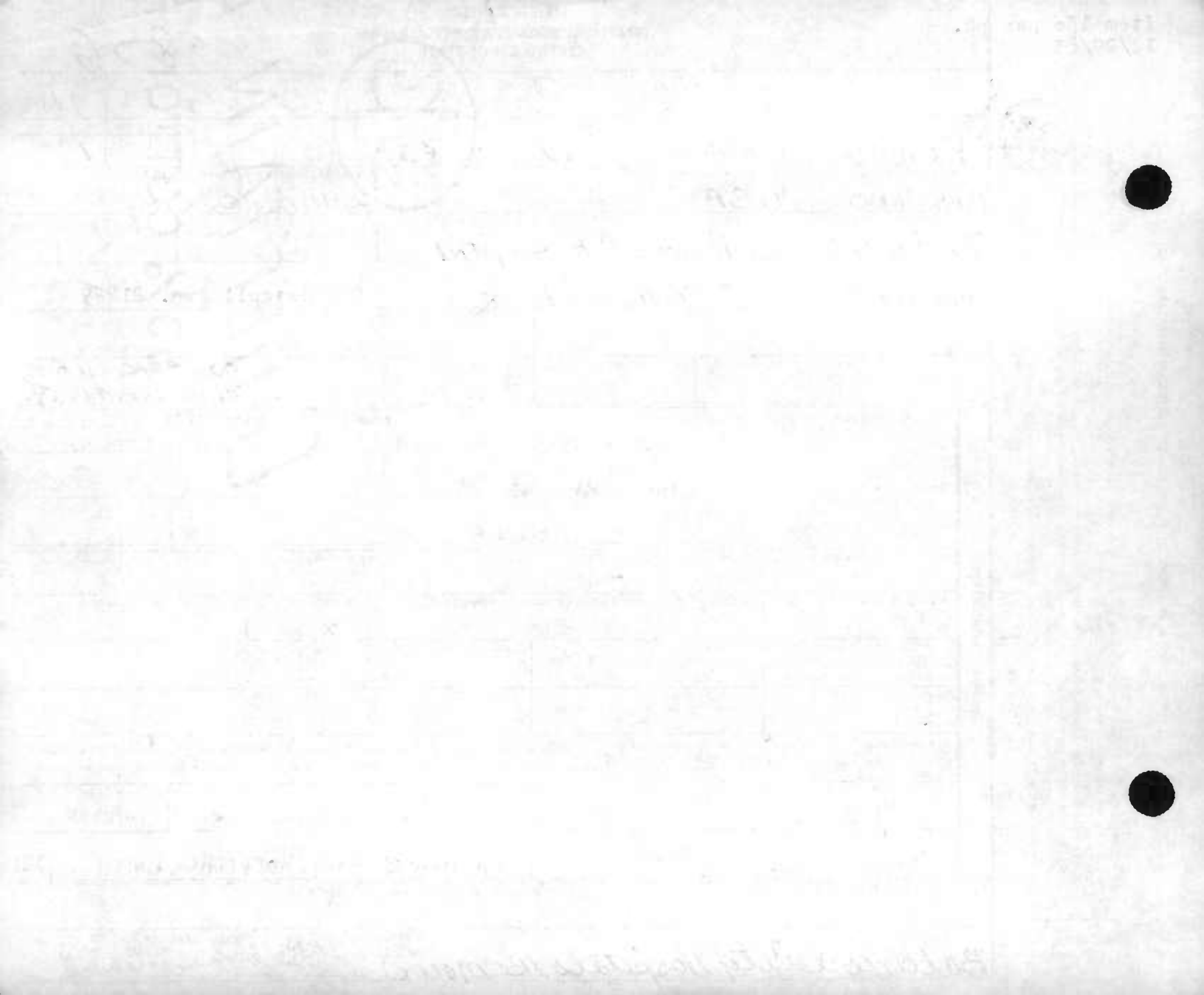
1. DECEASED NAME (TYPE OR PRINT) Lisa BG Rodgers		2a. DATE OF DEATH MONTH DAY YEAR 12 17 83		2b. HOUR 9:48 AM	
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 17 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 1 1 1	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore City		13c. STREET ADDRESS 922 Seagull Ave. 21225	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT MOTHER ADDRESS: 922 SEAGULL AVE. BALTIMORE 21225.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 7621 DUE TO, OR AS A CONSEQUENCE OF (b) PREMATUREITY DUE TO, OR AS A CONSEQUENCE OF (c) ABRUPTIO PLACENTA MEDICAL RECORDS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from December 17, 1983, to December 17, 1983, that (I) (we) last saw the deceased alive on December 17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard Zucker MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Zucker MD		22e. ADDRESS BALTIMORE CITY HOSPITAL, BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Baltimore City Hospitals (B. Moore)		ADDRESS		25. DATE RECEIVED BY REGISTRAR DEC 27 1983	
				REGISTRAR'S SIGNATURE John J. Carver	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5 4 877

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Sarah E. Rodgers		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
9 21 1906		77		Baltimore City	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12 7 1983		A. M.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Maryland		Baltimore		St. Agnes Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE	
Secretary		U S F & G		Maryland	
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Charles Barton Rodgers		Flora Clemmons		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
215-07-8547		Carol R. Ware		374 Centerhill Ave. 21090	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Pulmonary hemorrhage consistent with 4462					
DUE TO, OR AS A CONSEQUENCE OF, Goodpasture's syndrome.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from Dec 02, 19 83, to Dec 07, 19 83, that (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Bert F. Morton		M.D.		12/7/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
BERT F. MORTON		St. Agnes Hospital		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/9/83		Salem Luth Congregation	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. LOCATION	
Hubbard Funeral Home, Inc.		4107 Wilkens Ave.		CITY OR TOWN COUNTY STATE	
24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE		24e. DATE REC'D. BY REGISTRAR	
DEC 9 1983		John J. Canine		DEC 9 1983	

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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNE C. ROLLE										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-21-83	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 8, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 12-21-83 9:33 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9709 Harford Rd. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur F. Rolle, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna A. Shannahan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-26-3708		17. INFORMANT ADDRESS Arthur F. Rolle, Jr. 8009 Charlesmont Rd. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 8:22 P.M. 12-21-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by an auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION Harford Rd. 39ft. 81 Carney, Maryland Aspen Hill Rd.					
22. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-22-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-24-83		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 23 1983			
								REGISTRAR'S SIGNATURE John J. Caney			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR VOLUNTARY TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) SALLY ROSE					2a. DATE OF DEATH MONTH DAY YEAR 12-29-83				
3. SEX Female					2b. HOUR 12PM				
4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR 07-04-1905				
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.					7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale Nurs. Home				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper (RET)					12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN				
13a. STATE Maryland					13b. COUNTY -----				
13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Rosenblum					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Schlossman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 059-03-9736				
17. INFORMANT 8900 Boulevard East, N. Bergen, Mrs. Elaine Schwartz (sister) N.J.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA BREAST, WIDESPREAD									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 09-28 19 83 , to 12-29 19 83 , that (I) (we) last saw the deceased alive on 12-29 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. ZAWWIN, MD						DEGREE		22c. DATE SIGNED 12-29-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAWWIN, MD						22e. ADDRESS LEVINDALE GERIATRIC CTR 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 30 DEC 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Queens, New York		
24. FUNERAL DIRECTOR NAME J. Shannon ADDRESS 1100					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Jan 4 1984				
HEBREW MEMORIAL FUNERAL HOME, REISTERSTOWN									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Luella Rosebur				2b. HOUR M December 16, 1983			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 21 12		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ala.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2940 Edmondson Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2940 Edmondson Ave. 21223		14. FATHER'S NAME FIRST MIDDLE LAST John Simms		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Urchison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-24-5277		17. INFORMANT ADDRESS Lorenzo Meadows 2940 Edmondson Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Oct 31 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rebecca L. Tomlinack</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rebecca L. Tomlinack				22e. ADDRESS University Maryland Hospital Baltimore Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/83		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

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CHIEF MAN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			12			15		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR			8. UNDER 24 HRS		
FEMALE			White			MONTH			79			MONTHS			DAYS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK OR HOUS. OR WORKING LIFE)			11. KIND OF BUSINESS OR INDUSTRY		
MARYLAND			USA						City of Baltimore MD.			HOUSEWIFE			AT HOME		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR HOUS. OR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS			13b. CITY LIMITS?		
BALTIMORE			SINAI HOSPITAL			HOUSEWIFE						4718 Old Court Rd			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
MD			Balt			BALTIMORE			HERMAN			HANNAH			NO		
									FIRST			MIDDLE			LAST		
									CASSEL			SEGALL					
16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
218-52-0807			JAY M. ROSENBERG			4718 OLD COURT RD #21208			4100			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
						PART 1. DEATH WAS CAUSED BY:											
						IMMEDIATE CAUSE (a) Acute myocardial infarction											
						DUE TO, OR AS A CONSEQUENCE OF											
						Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
						(b) ASCVD, CHF											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c)											
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)											
						Diabetes COPD											
						21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
						21b. TIME OF INJURY											
						HOUR A.M. MONTH DAY YEAR											
						P.M. 19											
						21d. INJURY OCCURRED											
						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)											
						21f. LOCATION											
						STREET											
						CITY OR TOWN											
						COUNTY											
						STATE											
						22a. I certify that (I) (this hospital) attended the deceased from 12/5, 1983, to 12/5, 1983, that (I) (we) lost saw the deceased alive on 12/5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
						22b. SIGNATURE											
						E. Zimmerman											
						DEGREE											
						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
						22d. PHYSICIAN'S NAME (TYPE OR PRINT)											
						E. Zimmerman											
						22e. ADDRESS											
						Sinai Hospital Balt											
						23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
						BURIAL											
						23b. DATE											
						DEC. 5, 1983											
						23c. NAME OF CEMETERY OR CREMATORY											
						ANSHE EMUNAH											
						23d. LOCATION											
						BALTIMORE											
						CITY OR TOWN											
						COUNTY											
						STATE											
						MARYLAND											
						24. FUNERAL DIRECTOR											
						SOL LEVINSON & BROS., INC.											
						NAME											
						6010 REISTERSTOWN RD. BALTO. MD											
						25a. DATE REC'D. BY REGISTRAR											
						DEC 6 1983											
						25b. REGISTRAR'S SIGNATURE											
						[Signature]											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R. R. E. 18.5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EARLE ROSENFELD		2a. DATE OF DEATH MONTH DAY YEAR DEC. 15, 1983	
3 SEX MALE		2b. HOUR 10:55 PM	
4. RACE WHITE		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR JAN. 26, 1917		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT	
10. CITY OR TOWN OF DEATH BALTIMORE		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, STATE OF MARYLAND) SINAI HOSPITAL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STATE MARYLAND		13e. STREET ADDRESS / ZIP CODE 6807 PARK HEIGHTS AVE., APT. 2F #21215	
13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS ROSENFELD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FLEISHMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 213-01-6959	
16c. WWII ARMY		17. INFORMANT MRS. TILLIE ROSENFELD 6807 PARK HEIGHTS AVE., APT. 2F #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease & Cong. heart failure</u> <u>years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>79</u> , to <u>12/15</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>12/12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. Ronald Friedman</u>		22c. DATE SIGNED <u>MD</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Ronald Friedman</u>		22e. ADDRESS <u>6715 Park Heights Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-18-83	
23c. NAME OF CEMETERY OR CREMATORY SWINICHER WOLINER BEN. ASSN.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		25a. DATE REC'D. BY REGISTRAR DEC 20 1983	
25b. REGISTRAR'S SIGNATURE <u>John E. Connel</u>			

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INDEX

DOWN

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

3. The third part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1, after 24 hours, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elestine H. Ross			2a. DATE OF DEATH MONTH DAY YEAR XX 12 14 83			2b. HOUR 3:00 AM	
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 5 5 19		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1105 West Hamburg St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Julius Thomas Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Riffin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-16-8598		17. INFORMANT ADDRESS Charlie Ross (spouse) Same as #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary failure DUE TO, OR AS A CONSEQUENCE OF: (b) metastatic breast cancer to lungs DUE TO, OR AS A CONSEQUENCE OF: (c) Cancer Breast, metastatic to lungs and bone							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 1973		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 9 , 19 81 , to 11/14 , 19 83 , that (I) (we) last saw the deceased alive on 11/14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. S. Elias, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. George Elias, MD		22e. ADDRESS University of Maryland Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-14-83		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1983	
				25b. REGISTRAR'S SIGNATURE John J. Cairns			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Stanley lee Roth					2a. DATE OF DEATH MONTH DAY YEAR 12 7 83			2b. HOUR 12:00 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/20/97		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor		12b. KIND OF BUSINESS OR INDUSTRY mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY COUNTY Maryland Baltimore Halethorpe		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 4620 Magnolia Ave 21227					
14. FATHER'S NAME FIRST MIDDLE LAST John J. Roth					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice V.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705-05-0871		17. INFORMANT ADDRESS Mr. John G. Roth 1201 Sparrow Ct. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma unknown Primary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) duodenitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:10 12-7-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11:10 , 19 83 , to 12-7 , 19 83 , that (1) (yes) last saw the deceased alive on 12-7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (yes) (did) (did not) view the body after death.									
22b. SIGNATURE Purushottam Mitra				DEGREE		22c. DATE SIGNED 12-7-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAM MITRA				22e. ADDRESS ST. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR DEC 9 - 1983					
				25b. REGISTRAR'S SIGNATURE John G. Roth					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN L. ROTHAMEL			2a. DATE OF DEATH MONTH 12 DAY 30 YEAR 83			2b. HOUR 850A	
3 SEX Female		4 RACE CAUC White		5 DATE OF BIRTH MONTH 12 DAY 30 YEAR 16		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE MD.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST EDWARD MIDDLE G. LAST BISCHEL		15. MOTHER'S MAIDEN NAME FIRST LOUISE MIDDLE STROAH LAST STROAH					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217 09 1656		17 INFORMANT ADDRESS William G. Rothamel same as 13 E			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1539

IMMEDIATE CAUSE (a) **RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **CARCINOMA OF THE COLON**

DUE TO, OR AS A CONSEQUENCE OF

(c)

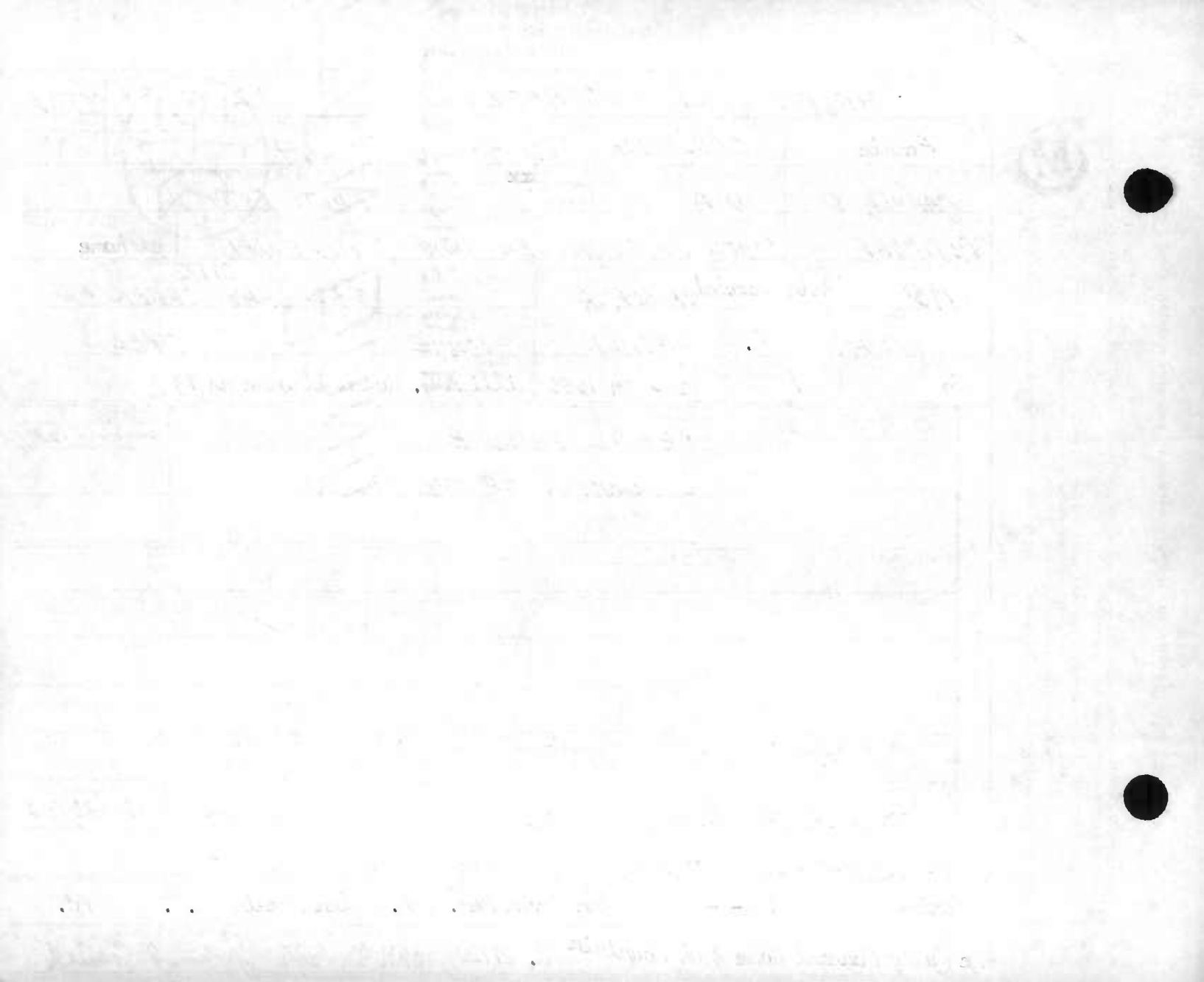
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ONSET \approx 12/10/83

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/5 , 19 83 , to 12/30 , 19 83 , that (1) (we) lost saw the deceased alive on 12/30 , 19 83 , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.							
22b. SIGNATURE David M. Witham				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID MATTHEW WITHAM				22e. ADDRESS 3001 S. HANOVER ST.			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1-3-84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.M. Md.	
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home ADDRESS 3204 Mountain Rd. 21122				25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

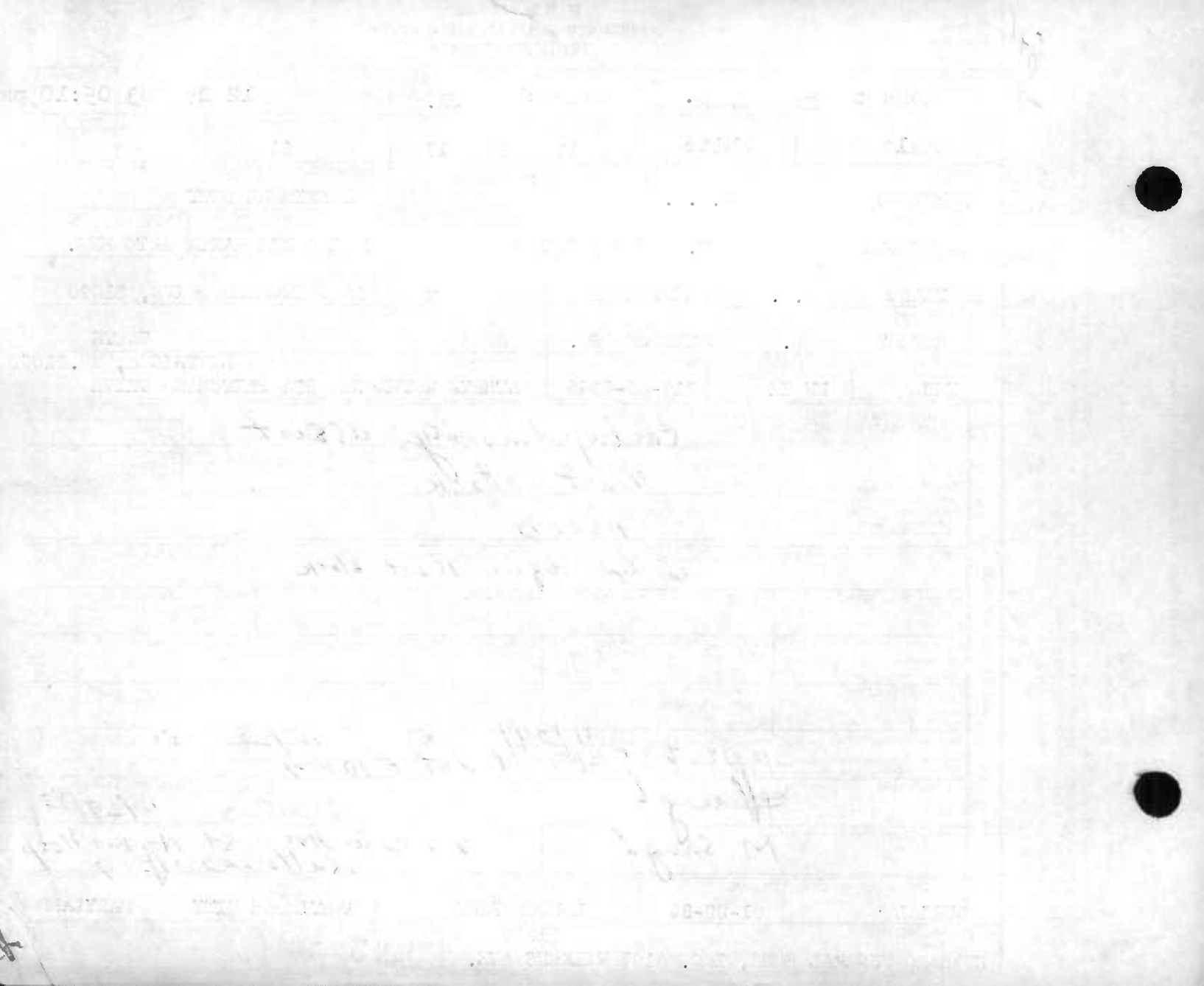


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will have to be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROBERT LAWRENCE ROTHROCK JR.				2a. DATE OF DEATH MONTH DAY YEAR 12 29 83		2b. HOUR 05:10 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 10 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DIE MAKER		12b. KIND OF BUSINESS OR INDUSTRY AUTO MFG.	
13a. STATE MARYLAND		13b. CITY OR TOWN A.A.	13c. CITY OR TOWN LINTHICUM	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT L. ROTHROCK SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA VAETH		13e. STREET ADDRESS / ZIP CODE 534 PRITCHARD DRIVE, 21090		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 215-05-6366		17. INFORMANT KATHRYN ROTHROCK		
16c. ADDRESS LINTHICUM, MD. 21090		16d. ADDRESS 534 PRITCHARD DRIVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>AS EVD</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>has high degree heart block</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/29/83</u> to <u>12/29/83</u> , that (I) (we) lost saw the deceased alive on <u>11/29/83 till 5:10 PM</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>obsd at 5:10 PM</u>						
22b. SIGNATURE <u>M. Singh</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/29/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Singh</u>		22e. ADDRESS <u>900 Caton Ave, St. Agnes Hosp Baltimore MD 21229</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-02-84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JAN 3 1984		
25b. REGISTRAR'S SIGNATURE						



Item 13a,b,c,d,e per ph. 1/13/84

FOR
1. STATE
REGISTRAR

kmg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ROY</u> <u>BARR</u> <u>KELLIE</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> <u>4</u> <u>83</u>		2b. HOUR <u>335</u> P.M.
3. SEX <u>F</u>	4. RACE <u>B</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>12</u> <u>4</u> <u>83</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>—</u> <u>—</u> <u>—</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. <u>—</u> <u>20</u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>USA</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>PROVIDENT HOSPITAL INC</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>md</u>			13b. COUNTY <u>BALTO</u>	13c. CITY OR TOWN <u>BALTO</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>LORENZO</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>KELLIE</u> <u>ROY</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

7650

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

SEPSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-4</u> 19 <u>83</u> , to <u>12-4</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-4</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Ethel Adelaye MD</u>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>12-4-83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ETHEL ADELOE</u>	22e. ADDRESS <u>PROVIDENT HOSPITAL INC.</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>	23b. DATE <u>12/4/83</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Provident Hospital</u>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1984</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

COPIES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER ROYAL JR.			2a. DATE OF DEATH MONTH DAY YEAR December 6 83			2b. HOUR 9:25a M			
3. SEX M		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR 2 7 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Blackstone, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick layer		12b. KIND OF BUSINESS OR INDUSTRY STEEL	

13a. STATE Md.			13b. COUNTY Balto			13c. CITY OR TOWN Balto			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1610 Moreland 21216		
14. FATHER'S NAME FIRST MIDDLE LAST Walter G. Royal						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Shelton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII				16b. SOCIAL SECURITY NO. 228 10 3911				17. INFORMANT ADDRESS Mrs. Doris E. Royal 1610 Moreland Ave.						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiration Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza pneumonia with complications DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 6 months	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (x) (this hospital) attended the deceased from Nov. 26 , 19 83 , to Dec. 6 , 19 83 , that (x) (we) lost saw the deceased alive on Dec. 6 , 19 83 , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brandt. MD				22e. ADDRESS 3900 Loch Raven Blv. Balto. Md 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-83		23c. NAME OF CEMETERY OR CREMATORY Crownsville V.A.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Jas. A. MORTON & SONS 1701 LAURENS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 8 1983 [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

83-23-35-300-1





[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. The text appears to be organized into sections or paragraphs, but the specific words and sentences are difficult to discern.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1. STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Rubin					2a. DATE OF DEATH MONTH DAY YEAR 12 3 83					2b. HOUR 12:59 PM
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MAY 12 14		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City of Baltimore MD				
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinar Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANF. REP.		12b. KIND OF BUSINESS OR INDUSTRY SALES CO.		
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. 1G #21215 6701 PARK HEIGHTS Ave		
14. FATHER'S NAME FIRST MIDDLE HARRY RUBIN		15. MOTHER'S MAIDEN NAME MIDDLE MINNIE ASHER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ANNE RUBIN APT. 1G 6701 Park Hts. ave. BALTO., MD 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from March , 19 83 , to Dec , 19 83 , that (I) (we) last saw the deceased alive on Dec - Nov , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did, did not view the body after death).										
22b. SIGNATURE Ira T. Fine M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira T. Fine M.D.				22e. ADDRESS 222 W. Cold Spring Lane 21210						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 5, 1983		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 6 1983						25b. REGISTRAR'S SIGNATURE John J. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Sonia L. Rubin</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12/24/83</u>			2b. HOUR <u>12:01 a.m.</u>							
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>4 28 09</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u>		7. IF UNDER 1 YEAR MONTHS DAYS <u>— —</u>		8. IF UNDER 24 HRS. HOURS MIN. <u>— —</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>POLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD							
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hosp of Baltimore</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>				
13a. STATE <u>MD</u>			13b. COUNTY <u>—</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. G #21215 <u>3915 Clarke Lane Apt C</u>				
14. FATHER'S NAME FIRST MIDDLE LAST <u>HOWARD AUERBACH</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>FRIEDA LEVITAS</u>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>							
16a. SOCIAL SECURITY NO. <u>219-07-3014</u>			17. INFORMANT ADDRESS <u>MR. HOWARD LICHTMAN</u> <u>6318 GREENSPRING AVE. APT. 207 (21209)</u>										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right hip fracture repair</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent Respiratory Failure & Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>Right hip fracture</u>													
19a. DATE OF OPERATION <u>11/24/83</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture Right Hip</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>11 23 1983</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Fell in home</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Home</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>3915 Clarke Lane Apt C Balto, MD</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> , 19 <u>83</u> , to <u>12/24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>[Signature]</u> MD		22c. DATE SIGNED <u>12/24/83</u> <u>12:15 am</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RE Perry</u> MD			22e. ADDRESS <u>Sinai Hospital</u>			22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>DEC. 25, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH ISAAC ADATH ISRAEL</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MARYLAND</u>					
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 29 1983</u>							
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 172-3000 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BG Ruble			2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 83			2b. HOUR 7:23 P.M.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 9 DAY 7 YEAR 83		6. AGE (IN YEARS LAST BIRTHDAY) NA YRS. MONTHS <1 DAYS 2 HOURS 30 MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. STATE MD			13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Michelle Ruble						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. NA			17. INFORMANT ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Extreme Prematurity**

7650

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Abortion, therapeutic**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

None

19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 7 , 19 83 , to Sept 7 , 19 83 , that (I) (we) last saw the deceased alive on Sept 7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cynthia J. Pearson, M.D. PhD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 9/7/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-16-83		23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Sinai Hospital				25a. DATE REC'D. BY REGISTRAR DEC 28 1983 REGISTRAR'S SIGNATURE John J. Gann			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

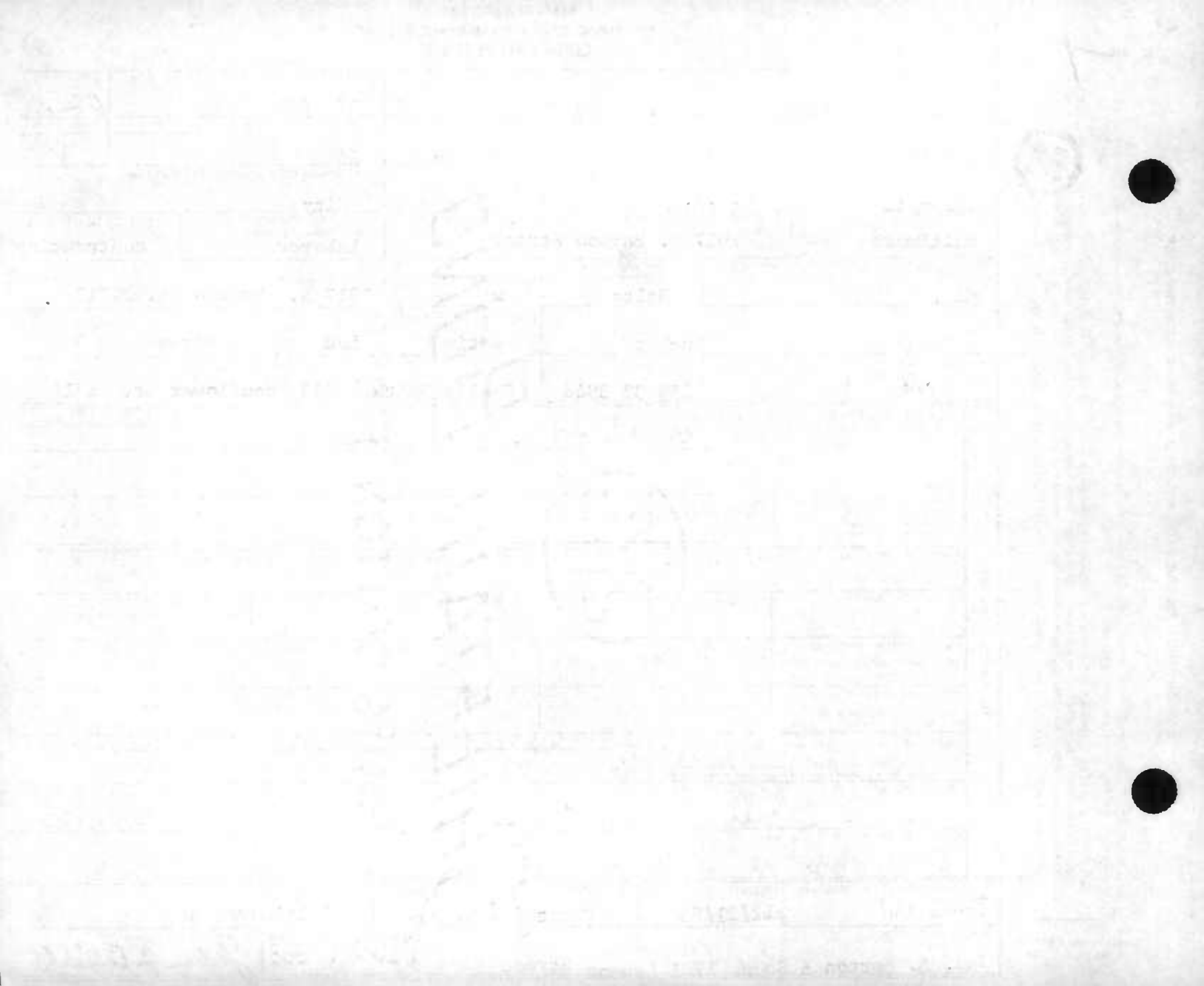
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
JOHN D. RUCKER				12/18/83				1:25 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		Black		MONTH DAY YEAR		56 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Georgia		U.S.A.				City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		1017 N. Payson Street				laborer		contracting	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.				Balto				1017 N. Payson St. 21217	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST		FIRST MIDDLE LAST	
Frank		Rucker		Katie		Lou		Stroud	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					258 32 3946		Shelia Smith 6623 Moonflower Ct. 21214		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE									
1629 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) LUNG CANCER									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18/83, 19, to 12/18/83, 19, that (I) (we) lost									
saw the deceased alive on 12/16/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Edward W. Schaefer					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			12/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
EDWARD W. SCHAEFER					730 ASHBURTON ST. 21216				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12/21/83		King Man B.K.		Baltimore, Md			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS					DEC 20 1983		John J. Connel		
Jas. A. Morton & Sons 1701 Lavens Street									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALBERT H. RUCKLE			2a. DATE OF DEATH MONTH 12 DAY 16 YEAR 83		2b. HOUR 11:15 A.M.
1. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 7 DAY 25 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Balto., Md. 2307 Lorretta Ave. #21223		
14. FATHER'S NAME FIRST Walter MIDDLE L. LAST		15. MOTHER'S MAIDEN NAME FIRST Minna MIDDLE Poezolt LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) I		16b. SOCIAL SECURITY NO. 215-05-7687		17. INFORMANT 1119 Gloria Ave. Balto., Md. Frances Ruckle #21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Myocardial Ischemia, 2° to Coronary insufficiency 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure. Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, Urinary Tract Infection, Anemia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from 12-11- 19 83 , to 12-16- 19 83 , that (I) (we) lost saw the deceased alive on 12-16- 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Philip M Lam		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-16-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP M LAM		22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-19-83	23c. NAME OF CEMETERY OR CREMATORY Md. Vets. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.	
24. FUNERAL DIRECTOR NAME G. Truman Schwab		24b. ADDRESS 5751 Balto. Nat'l. Pike # 21229		25a. DATE REC'D. BY REGISTRAR DEC 27 1983	
		25b. REGISTRAR'S SIGNATURE John J. Connelley			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see page 35).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 3 3 2 8 9 4				
1. DECEASED NAME (TYPE OR PRINT) <i>MARY J RUPPERT</i>					2a. DATE OF DEATH MONTH DAY YEAR 12 30 83				
3. SEX <i>F. Female</i>					4. RACE <i>White</i>				
5. DATE OF BIRTH MONTH DAY YEAR 2 18 96					6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.				
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian/Hamilton Nursing Center</i>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>telephone operator</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>phone</i>				
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Balto.</i>				
13c. CITY OR TOWN <i>Balto.</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS <i>4909 Morello Rd. 21214</i>									
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Deichelbore</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>214-03-5552</i>				
17. INFORMANT ADDRESS <i>Mrs. Frances Wills 4909 Morello Rd. 21214</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCD with pulmonary embolism and cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1 month</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>fracture, Osteoarthritis of spine</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/15/79</i> to <i>12/30/83</i> , that (I) (we) last saw the deceased alive on <i>12/29/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>I. W. Fromm, M.D.</i> DEGREE						22c. DATE SIGNED <i>Jan. 2 1984</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>I. W. Fromm, M.D.</i>						22e. ADDRESS <i>8014 Old Harford Road, Balto., 21234</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Jan 3 1984</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer</i>			
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>									
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc. Baltimore, Maryland</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 3 1984</i>			
						25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

BP _____

Leonard J. Luck, Inc., Baltimore, Maryland

Serial

Jan 7 1984

Mont Holy Redeemer

Baltimore

Maryland

I. W. Young, N.D.

6014 Old Harford Road, Beltsville, MD 21034

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DANIEL RUTHERFORD		2a. DATE OF DEATH MONTH DAY YEAR December 4, 1983		2b. HOUR 10:45p_M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 31 24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Tom Rutherford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Carson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 239 22 2072		17. INFORMANT ADDRESS Ruth Rutherford 4018 Wilsby Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SCCA of pharynx and mouth 1490 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 20 , 19 83 , to December 4 , 19 83 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 4 , 19 83 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
22b. SIGNATURE Bolignano MD		DEGREE		22c. DATE SIGNED 12/5/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD B. BOLIGIANO		22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/9/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STANDARD FORM NO. 64

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETAIN PAGE 4. THIS CERTIFICATE SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Billy Rutledge										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 2 1983	
3. SEX male		4. RACE Col		5. DATE OF BIRTH MONTH DAY YEAR 6-13-42		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 41		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 2 1983		2b. HOUR 3:10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Anderson Co. S.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1929 N. Gay Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1829 N. Gay St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Rozell Rutledge				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Synola Reedes				17. INFORMANT ADDRESS Johnson Funeral Home Anderson S.C. 29621			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Chronic <input checked="" type="checkbox"/> Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12/3/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anderson Co. S.C.			
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2222 W. North				25a. DATE REC'D. BY REGISTRAR DEC 13 1983		25b. REGISTRAR'S SIGNATURE John J. Carney	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32897

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANK C. RYNES			2a. DATE OF DEATH MONTH 12 DAY 28 YEAR 83 2b. HOUR 10:00P		
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 28 YEAR 05	6. AGE (IN YEARS LAST BIRTHDAY) 78 IF UNDER 1 YEAR: MONTHS 0 DAYS 0 HOURS 0 MIN 0		
7a. BIRTHPLACE COUNTRY MD (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electric Supply		12b. KIND OF BUSINESS OR INDUSTRY Elec Supply Bus.
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5020 Pilgrim Rd 21214	
14. FATHER'S NAME FIRST Thomas MIDDLE Rynes LAST Rynes		15. MOTHER'S MAIDEN NAME FIRST Josephine MIDDLE PLUHART LAST PLUHART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-05-1092		17. INFORMANT EDNA G Rynes ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4920 DUE TO, OR AS A CONSEQUENCE OF (b) Cold - Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/27/83 19 83 to 12/28 19 83 , that (I) (we) lost saw the deceased alive on 12/28 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Shamida Siddique DEGREE MD				22c. DATE SIGNED 12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAMIDA SIDDIQUE				22e. ADDRESS Good Samaritan Hosp.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/83		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	
23d. LOCATION CITY OR TOWN BALD COUNTY MD STATE MD		23e. DATE REC'D BY REGISTRAR DEC 30 1983			
24. FUNERAL DIRECTOR NAME Leonard J. Rockine ADDRESS 5305 Harford Rd					
25a. DATE REC'D BY REGISTRAR DEC 30 1983 25b. REGISTRAR'S SIGNATURE Shamida Siddique					

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Q.M.

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Richard Alexander